



PAYMENT FORM

Date: _____

(Please print and complete all information. Parent or legal guardian please sign below)

Patient Name: _____ M / F (Circle) Date of Birth : _____

Address: _____ City: _____ Phone: _____

Parent Name: _____ Dr. Name: _____

In the state of IL, have you/or child been on WIC or other health dept. program? Yes / No
If you have ever been known by another name? Yes: _____ No

(Client must bring current Medicaid card containing person's name receiving service).

Recipient (Medicaid) I.D. Number _____

Received: Cash _____ Check _____ Bill Client _____

(Please advise if you will need a receipt for this service)

- | | | | |
|-------|--------------------------|-------------------|-------|
| _____ | <input type="checkbox"/> | DTap | 90700 |
| _____ | <input type="checkbox"/> | Hep A - Havrix | 90633 |
| _____ | <input type="checkbox"/> | Hep B | 90744 |
| _____ | <input type="checkbox"/> | Hib - Acthib | 90648 |
| _____ | <input type="checkbox"/> | HPV (Gardasil) | 90649 |
| _____ | <input type="checkbox"/> | IPV (Polio) | 90713 |
| _____ | <input type="checkbox"/> | Kinrix Dtap-IPV | 90696 |
| _____ | <input type="checkbox"/> | Meningitis (mcv4) | 90734 |
| _____ | <input type="checkbox"/> | MMR | 90707 |

- | | | | |
|-------|--------------------------|----------------------|-------|
| _____ | <input type="checkbox"/> | MMRV - ProQuad | 90710 |
| _____ | <input type="checkbox"/> | Pediarix | 90723 |
| _____ | <input type="checkbox"/> | Pentacel | 90698 |
| _____ | <input type="checkbox"/> | Prevnar 13 | 90670 |
| _____ | <input type="checkbox"/> | Rotateq | 90680 |
| _____ | <input type="checkbox"/> | Rotarix | 90681 |
| _____ | <input type="checkbox"/> | TD Decavac | 90714 |
| _____ | <input type="checkbox"/> | Tdap Adavel/Boostrix | 90715 |
| _____ | <input type="checkbox"/> | Varicella | 90716 |

Education: Explained to client the following: VIS (Vaccine Information Statement) forms, all components of each vaccine, and answered clients questions and / or concerns.

Nurse's Signature: _____

I authorize the service provider to bill and release information to the IL Department of Public Aid for service received today if applies, otherwise I take full responsibility for payment.

Signed: _____

Date: _____

- - - CONTINUED ON THE BACK SIDE - - -

Jo Daviess County Health Department Immunization Questionnaire and Consent Form

Please answer questions by checking the box. If a question is not clear, please ask a nurse.

	YES	NO	COMMENTS
Is the child/self sick today?			
Does the child/self have allergies to medications, food or vaccine?			
Has the child/self ever had a serious reaction after receiving a vaccination?			
Does the child/self have cancer, leukemia, AIDS, organ transplant, or any other immune system problem?			
Does the child/self take cortisone, prednisone, other steroids, anticancer drugs, or had x-ray treatments in the past 3 months?			
Has the child/self has a seizure, brain or nerve problem?			
During the past year, has the child/self received a transfusion of blood products, or been given a medicine called Immune (gamma) globulin?			
Have you received any vaccinations in the past 4 weeks?			
FOR FEMALES ONLY: Is the child/teen pregnant or is there a chance she could become pregnant during the next month?			

Reviewed By _____

I hereby give my consent for the Jo Daviess County Health Department (JDCHD) to immunize:

Print Child's Name

Date of Birth

and will not hold either the JDCHD or member of its staff liable for any reactions. I also give my consent for the JDCHD to release child's immunization information to physician, school officials and specified family members upon request. I have been given the appropriate vaccine information statements and have had the opportunity to ask questions.

Parent's Signature

Date