



*

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: _____

School Name: _____

Recipient (Medicaid) I.D. Number _____ Managed Care Provider : _____

Received: Cash _____ Check _____

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

I have received a copy of the Jo Daviess County Health Department's Notice of Privacy Practice: _____

- | | | | |
|-------|--------------------------|-------------------|-------|
| _____ | <input type="checkbox"/> | DTap | 90700 |
| _____ | <input type="checkbox"/> | Hep A - Havrix | 90633 |
| _____ | <input type="checkbox"/> | Hep B | 90744 |
| _____ | <input type="checkbox"/> | Hib | 90648 |
| _____ | <input type="checkbox"/> | HPV (Gardasil 9) | 90651 |
| _____ | <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(DTAP-IPV-Hep B) | 90723 |
| _____ | <input type="checkbox"/> | Influenza | 90685/86 |
| _____ | <input type="checkbox"/> | Prevnar 13 | 90670 |
| _____ | <input type="checkbox"/> | Men B | 90620 |
| _____ | <input type="checkbox"/> | Rotarix | 90681 |
| _____ | <input type="checkbox"/> | TD | 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	Not Applicable
1. Is the child/self-sick today?			
2. Does the child/self-have allergies to medications, food or vaccine component, or latex?			
3. Has the child had a serious reaction to a vaccine in the past?			
4. Does the child have a long-term health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder, no spleen, complement component deficiency, a cochlear implant, or spinal fluid leak? Is he/she on long-term aspirin therapy?			
5. If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?			
6. If your child is a baby, have you ever been told he/she had intussusception?			
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?			
8. Does the child or a family member (parent, brother, sister) have cancer, leukemia, HIV/AIDS, or any other immune system problems?			
9. In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?			
10. In the past year, has the child received a transfusion of blood or blood products, or been given a medicine called Immune (gamma) globulin or an antiviral drug?			
11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?			
12. Has the child/self-received vaccination in the past 4 weeks?			

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