Central Utah Public Health Department Registration Form

Last Name	First Name	Female Male	Date of Birth	Age

Mailing Address	City	State	Zip	Phone#

Race: (Please circle one) White Asian Black Pacific Islander Native American/Alaskan Native Other

Hispanic Yes No

For Office Use Only

VFC: Medicaid#_____ No insurance Native American/Native Alaskan Underinsured Chip
Adult Medicaid #_____ Medicare #_____ Medicare HMO Name:_____
Insurance: PEHP Select Tall Tree DMBA PCN EMI BCBS Humana PPO United TriCare Cigna
Insurance #:_____ Group #: _____
Name of Insured: _____ Relationship _____
Self-Pay Amount: Cash _____ Check # _____ Credit Card _____ Receipt # _____

CLERK'S INITIAL _____

Please answer the following questions:

* Is the person to be vaccinated sick today? (fever or very stuffy nose)	Yes	No
* Does the person to be vaccinated have an allergy to eggs, gelatin, thimerosal or other vaccine component?	Yes	No
* Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?*	Yes	No
* Has the person to be vaccinated ever had Guillain-Barré syndrome?	Yes	No
* Is the person to be vaccinated pregnant?	Yes	No

SCREENER'S INITIAL _____

CONSENT FOR TREATMENT AND PRIVACY NOTICE

I certify that the information I have provided is true and accurate. I have been given a copy and have read, or have had explained to me, the information contained in the Vaccine Information Statement (VIS) about the disease. I have had a chance to ask questions, which were answered to my satisfaction.
I believe I understand the benefits and risks of the influenza vaccine(s) indicated be given to the person named above for whom I am authorized to make this request.
I agree that this information may be shared with schools, daycare centers, health care providers and others when deemed medically necessary.
I hereby release the Central Utah Public Health Department, and their employees, from all claims arising from such immunizations.
I authorize Medicaid or insurance benefits to be paid to the Central Utah Public Health Department or its authorized agent and for CUPHD or its authorized agent to release information to Medicaid or insurance companies as necessary to claims. I understand that I may be liable for all or a portion of the bill.

Notice of Privacy Practices and Acknowledgement of receipt. EFEECTIVE: April 14, 2003

The Notice of Privacy Practices tell you how CUPHD may use or disclose information about you. Not all situations will be described. CUPHD is required to inform you of our privacy practices for the information we collect and keep about you**. I have been given a copy of CUPHD's Notice of Privacy Practices and have had a chance to ask questions about how my information could be used.**

X_____ _____Date_____ _____
Signature of patient or parent/legal guardian.

Vaccine	Lot #	Dose	Site	Vaccinator Signature
VFC Flu 6 - 35 mo 90685		.25 mL	LVL RVL	
VFC Flu >3 - <18 yrs 90686		.5 mL	LD RD	
Flu 6 - 35 mo 90685		.25 mL	LVL RVL	
Flu >3 - <18 yrs 90686		.5 mL	LD RD	
Flu – High Dose >65 yrs 90662		.5 mL	LD RD	

Flu VIS 08/07/2015