Southwest Utah Public Health Department – Intake Form

All information is strictly confidential - All items MUST be completed

(*Please Print*)

Date: ____________________

Patient Last Name	First Name	MI	Date of Birth (mm/dd/yyyy)	Age

Race	Ethnicity	Language	Gender
☐ White ☐ Black ☐ Asian ☐ American Indian ☐ Alaskan Native ☐ Pacific Islander	☐ Hispanic ☐ Non Hispanic		☐ Male ☐ Female

Address	City	State	Zipcode

Primary Phone #	Best Form of Contact	☐ Phone Call ☐ Text ☐ Email	Email:

Primary Health Insurance	Policy #	Policy Holder (Exact Name listed on Card)

Insurance Policy Holder Date of Birth (mm/dd/yy)	Relationship to Patient	Address of Policy Holder

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 important Vaccine Information Statements. I have had a chance to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccines and request that the vaccines 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, day care centers, health care providers and others when deemed medically necessary. I HEREBY RELEASE SOUTHWEST UTAH PUBLIC HEALTH DEPARTMENT, AND ITS EMPLOYEES, FROM ALL CLAIMS ARISING FROM SUCH IMMUNIZATIONS.

I UNDERSTAND THE BILLING OF MEDICAL INSURANCE DOES NOT GUARANTEE PAYMENT AND THAT I AM RESPONSIBLE FOR ANY UNPAID BALANCE.

We are required to inform you of our privacy practices for the information we collect and keep about you. I have been given a copy of the Health Department's Notice of Privacy Practices and have had an opportunity to ask questions about how my information may be used.

Full Name: ______________________________Signature: ____________________ Date: _____________

Relationship to Patient: ☐ **Self** ☐ **Parent** ☐ **Legal Guardian** ☐ **Other**

Immunization Screening Questionnaire	**Yes**	**No**
Is the individual sick today?		
Does the individual have allergies to medications, food or vaccine components? If yes, list ____		
Has the individual ever had a serious reaction after receiving a vaccine? Describe.		
Has the individual ever had Guillain-Barré Syndrome; epilepsy or other nervous system problems?		
Does the individual have a condition or undergoing treatment that causes a weakened immune system? Ex. Diabetes, cancer, leukemia, lymphoma, HIV/AIDS or therapies, high-dose corticosteroids or others		
Is the individual, or will the individual be, at risk for blood borne infections such as HIV, AIDS, or Hepatitis B and C?		
Has the individual received a transfusion of blood, blood product, or medication called immune (gamma) globulin?		
Has the individual received any vaccination in the past 4 weeks?		
Does the individual smoke?		
For all: Has the individual had Chickenpox Disease? For children only: If yes, Month ______ and Year ______		
Females: Is the individual pregnant, at risk of becoming pregnant in the next month or currently breastfeeding?		
Additional COVID Vaccine Questionnaire	**Yes**	**No**
Has the individual received a dose of COVID-19 vaccine? If yes, which vaccine?		
Has the individual had blood disorder, myocarditis/pericarditis, heparin-induced thrombocytopenia or Multisystem Inflammatory Syndrome?		

TB Test Only Screening Questionnaire	**Yes**	**No**
Has the individual received any vaccinations is the past 4 weeks?		
Has the individual ever received BCG (tuberculosis) vaccine?		
Have you ever been diagnosed with latent or active tuberculosis?		
Have you ever had treatment for tuberculosis?		
Date of last TB test: ________________ Results: _________________________		

PPD Placed Date ___________ Time: __________ JHP Aplisol 5 TU/0.1ml Lot # __________ **Site: LFA RFA** Nurse: _________

PPD Read Date: _____________ Time: ___________ mm Results: ____________ Results read by: _________________________

☐ TB Screening Questionnaire Nurse: ________________ ☐ QFT Referral Nurse: __________________ Referred to: _________________

For Health Department Use ONLY

District Vaccine			
Vaccine		**Vaccine**	
Adacel 10–64 yrs		Peds Hep A 12mo–18yrs	
Adult Hep A 19 yrs+		Peds Hep B 0 – 19 yrs	
Adult Hep B 20 yrs+		Pentacel 2 mo – 4 yrs	
Bexsero 10-25 yrs		Pneumovax 23 2 yrs+	
Boostrix 10 yrs +		PF Flu 6 mo & up	
DTaP 2 mo – 6 yrs		Prevnar13 6 wks+	
FluBlok 50 yrs+		Prevnar20 18 yrs+	
Fluzone MD 6 mo+		Quadracel 4– 6 yrs	
Heplisav-B 18 yrs+		Rabies	
HIB 2 mo – 4 yrs		Rotarix 6 wks – 7 mo	
HD Flu 65 yrs+		Rotavirus 6 wks–7 mo	
IPV (Polio) 6 wks+		Shingrix 50 yrs+	
Kinrix 4 - 6 yrs		TD 7 yrs & up	
MenQuadfi 2 yrs+		Twinrix 18 yrs+	
MMR (Live) 12 mo+		Varicella (Live) 12 mo+	
Pediarix 2 mo–6 yrs			

VFC Vaccine			
Vaccine		**Vaccine**	
Adacel 10–64 yrs		Peds Hep A 12mo–18yrs	
Bexsero 10-25 yrs		Peds Hep B 0 – 19 yrs	
Boostrix 10 yrs +		Pentacel 2 mo – 4 yrs	
DTaP 2 mo – 6 yrs		Prevnar13 6 wks+	
Fluzone MD 6 mo+		Quadracel 4– 6 yrs	
HIB 2 mo – 4 yrs		Rotarix 6 wks – 7 mo	
IPV (Polio) 6 wks+		Rotavirus 6 wks–7 mo	
Kinrix 4 - 6 yrs		TD 7 yrs & up	
MenQuadfi 2 yrs+		Varicella (Live) 12 mo+	
MMR (Live) 12 mo+		Vaxelis 6wks-4yrs	
Pediarix 2 mo–6 yrs			

Special Projects Vaccine			
Vaccine		**Vaccine**	
Adacel 10–64 yrs		Heplisav-B 18 yrs+	
Adult Hep A 19 yrs+			

Medicare Procedures			
Vaccine		**Vaccine**	
Adult Hep B		HD Flu 65+	
Flu Reg		Pneumovax 23	
FluBlok		Prevnar 13	
Heplisav-B		Prevnar 20	

Travel Vaccines			
Vaccine		**Vaccine**	
Japanese Enc 2mo+		Typhoid Vi 2yrs+	
Typhoid Oral 6yrs+		Yellow Fever 9mo-60yrs	
Deet ☐ 3oz ☐ 6oz		**Permethrin** ☐ 12oz ☐ 24 oz	
Consult ☐ Missionary ☐ Travel x1 ☐ Travel x2 ☐ Travel x 3 ☐ Travel x 4-8			

COVID Primary Series Vaccine
Moderna 12yrs+
Moderna 6-11yrs
Moderna 6mo-5yrs

COVID Bivalent Vaccine
Moderna Bivalent 6yrs+
Moderna Bivalent 6mo-5yrs

Vaccine	Lot #	Dose	Category	Site	Payment Information
					☐ Cash ___________ ☐ Card ______________
					☐ Check # ____________ ☐ Voucher
					Notes:
					RN:

For Health Department Use ONLY:	Gross Monthly Income: _____________ # of Family Members: _______ PFR: ______________________________________ RN: ___________________

Updated 12/30/2022