Southwest Utah Public Health Department – Intake Form

All information is strictly confidential - All items MUST be completed

(*Please Print*)

Patient Last Name	First Name	Middle	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	Unit/Apt	City	State	Zip code

Primary Phone #	☐ Cell ☐ Home ☐ Work	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

↓ Sign Here

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, others when deemed medically necessary, and the Utah State Immunization Registry.

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.

X Signature _____ Print Name: _____ Date: _____

Relationship to Patient: ☐ **Self** (Must be 18 or older) ☐ **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? _____		
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, or a family history of seizures?		
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, or have a family history of congenital immune system problems?		
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, or is the individual taking aspirin or have a condition that causes them to bruise or bleed easily?		
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?		
Has the individual had HCT or CAR-T cell therapy since receiving the COVID vaccine?		

Tuberculosis (TB) Test Screening Questionnaire	**Yes**	**No**
Has the individual had a previous TB skin test: If so, date of last test _____ and results _____		
Has the individual ever had a QuantiFERON (QFT) blood test to check for TB disease? If so, what were the results? _____		
Has the individual ever been diagnosed with latent or active tuberculosis?		
Has the individual had treatment for tuberculosis?		
Has the individual received any vaccinations in the past 4 weeks?		
Has the individual ever received BCG (tuberculosis) vaccine?		

For Health Department Use ONLY

Patient Name _____ **Patient ID _____**

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: _____

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		Prevnar 13 6 wks+
FluBlok 50 yrs+		Prevnar 20 6 wks+
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+		RSV - Arexvy / Abrysvo 60 yrs+
MenQuadfi 2 yrs+		Shingrix 50 yrs+
MMR (Live) 12 mo+		TicoVac 12 mo+
Moderna 6m-11y		TD 7 yrs & up
Moderna 12 yrs+		Twinrix 18 yrs+
Pediarix 2 mo–6 yrs		Varicella (Live) 12 mo+

VFC Vaccine (through age 18y)

Vaccine		Vaccine
Adacel 10–64 yrs		Pediarix 2 mo–6 yrs
Bexsero 10-25 yrs		Peds Hep A 12mo–18yrs
Beyfortus ≤ 2 yrs		Peds Hep B 0 – 19 yrs
Boostrix 10 yrs +		Pentacel 2 mo – 4 yrs
DTaP 2 mo – 6 yrs		PCV 13 / 15 / 20 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
MenQuadfi 2 yrs+		TicoVac 12 mo+
MMR (Live) 12 mo+		TD 7 yrs & up
MMRV (Live) 12 mo+		Varicella (Live) 12 mo+
Moderna 6m-11y		Vaxelis 6wks-4yrs
Moderna 12 yrs+		

Special Projects Vaccine (19+)

Vaccine		Vaccine
Adacel 10–64 yrs		Heplisav-B 18 yrs+
Adult Hep A 19 yrs+		Moderna 12 yrs+

Medicare Procedures

Vaccine		Vaccine
Adult Hep B		Pneumovax 23
Flu Reg		Prevnar 13
FluBlok		Prevnar 20
Heplisav-B		Moderna 12 yrs+
HD Flu 65+		RSV - Arexvy / Abrysvo 60 yrs+

Travel Vaccines

Vaccine		Vaccine
Japanese Enc 2mo+		Typhoid Vi 2yrs+
Typhoid Oral 6yrs+		Yellow Fever 9mo-60yrs

Labs & Screenings

A1C	Blood Glucose
Body Mass Index (BMI)	Blood Pressure
Lipid Panel	Pre-diabetes Screening

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 9/13/2023