Jersey County Health Department
1307 State Hwy 109, Jerseyville IL 62052

Name
Last Name: _____First: _____M.I.: ___Date of Birth:___/___/___Age:____

Address: _____City: _____State: _____Zip: _____

Phone: _____Guardian (if applicable): _____

Insurance Information

☐ Medicaid ☐ Medicare ☐ Uninsured or Under-insured (qualifies for VFA program) ☐ Self Pay

☐ Private Insurance: _____ Policy holder:_____

Member ID#_____ Group#: _____

Put an "x" in the box below to indicate that you have the HIPAA information.

☐ **HIPAA** – I understand a *Notice of Privacy Practices* is available at my request. Under the Healthcare Insurance Portability and Accountability Act, I authorize to disclose my Immunization Record to my physician and/ or school. I also authorize the following person(s) to have access to my records:
(*It's OK if you don't write anyone's name)* _____

Adult Screening Checklist for Contraindications to Vaccines

The following questions will help us to determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask clinic staff to explain it.

		Yes	No	Don't Know
1.	Are you sick today?	☐	☐	☐
2.	Do you have allergies to medications, food (including eggs), a vaccine component, or latex? If yes, list here:	☐	☐	☐
3.	Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4.	Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
5.	In the past 3 months, have you taken medications that weaken your immune system, (cortisone, prednisone, other steroids, or anticancer drugs) or have you had radiation treatments?	☐	☐	☐
6.	Have you had a seizure or a brain or other nervous system problem, including Guillain-Barre syndrome?	☐	☐	☐
7.	During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug, including influenza antiviral medications?	☐	☐	☐
8.	For women: Are you pregnant or breastfeeding, or is there a chance of you becoming pregnant during the next month?	☐	☐	☐
9.	Have you received any vaccines in the past 4 weeks?	☐	☐	☐
10.	Do you live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (such as for a bone marrow transplant)?	☐	☐	☐

"I have completed this form to the best of my knowledge. I have been given, read, and understand the possible side effects described in the Vaccine Information Statement that could be caused by the vaccine(s). I give my consent for vaccines to be administered as indicated. I authorize JCHD to release service-related information regarding the above-mentioned person to third party payors and to bill for services rendered to me if applicable. I request my payor to pay JCHD directly for services rendered to me. I agree to pay JCHD for any services not covered or paid by my insurance, and I understand that JCHD may bill me for this amount."

Signature: _____ Date: _____
(client or guardian must sign)

Nurse Reviewing Form: _____ Date: _____