HAMPSHIRE COUNTY HEALTH DEPARTMENT
2023-2024 CHILD/TEEN INFLUENZA IMMUNIZATION REGISTRATION/CONSENT FORM

Patient Information		
Last Name:	First Name:	Middle Initial:
Mailing Address:		
City:	State:	Zip Code:
Home Phone:	Cell Phone:	
Date of Birth:	Sex: Male ☐ Female ☐	Mother's Maiden Name:
Primary Care Physician or Pediatrician:		
Email:		
Preferred Method of Contact: Email ☐ Phone ☐ Text ☐ Mail ☐		

Responsible Party		
Last Name:	First Name:	Middle Initial:
Relationship to Patient:	Marital Status: S M D W	
Date of Birth:	Social Security Number:	Phone:
Address (if different from above):		
City:	State:	Zip Code:

Screening Questions for Child and Teen Immunization	**Yes**	**No**	**Unsure**
Is the child sick today?			
Does the child have allergies to latex, medications, food, or any vaccine?			
Has the child had a serious reaction to a vaccine in the past?			
Has the child ever felt dizzy or faint before, during, or after a shot?			
Has the child had a health problem with heart, lung, kidney, or metabolic disease (e.g. diabetes), asthma, or a blood disorder?			
Is he/she on long term aspirin therapy?			
If the child to be vaccinated is between the ages of 2 and 4 years, has the healthcare provider told you that the child had wheezing or asthma in the past 12 months?			
Has the child, a sibling or parent had a seizure; has the child had brain or other nervous system problems?			
Does the child have cancer, leukemia, AIDS, or any other immune system problem?			
In the past 3 months, has the child taken cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?			
In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?			
Is the child/teen pregnant or is there a chance she could become pregnant during the next month?			
Has the child received vaccinations in the past 4 weeks?			

The HCHD Notice of Privacy Practices provides information about how we may use and disclose your protected information. The Notice of Privacy Practices is subject to change. A copy of our notice is available upon request. By signing this form, you acknowledge that they HCHD Notice of Privacy Practices was made available to you.

I have read or had explained to me the Vaccine Information Statement for the vaccine I am to receive, and I understand the risk and benefits. Vaccine Information Statements (VIS Forms) have been made available to me and I understand the information about the vaccine(s). Hampshire County Health Department can bill the insurance listed for the immunizations. I request that payment of authorized third-party benefits be made to Hampshire County Health Department for services furnished by the department. ***Submission of insurance information does not guarantee coverage. I understand that if the insurance company does not cover the vaccine(s), I will be responsible for payment.***

Parent/Legal Guardian Signature: ____ **Date:**________________

Witness/Title: ____ **Date:**_________________

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Hampshire County Health Department Use

Primary Medical Insurance		
Insurance Company Name:		
Insurance Company Address:		
City:	State:	Zip Code:
Insurance Company Phone Number:		
Policy Holder Name:		
Policy Holder Date of Birth:	Relationship:	
Policy Identification Number:		
Group Number:		

Influenza

____ VFC ____Private

Lot # ________________

R deltoid L deltoid

Nurse Initial:______________

Hampshire County Health Department
Tamitha L. Wilkins, RN
Erin D. Jacobsen, RN
Carolyn J. Kimble, RN
16189 Northwestern Pike
Augusta, WV 26704
Phone: 304-496-9640
Fax: 304-496-9650
NPI: 1750489415
Bryan M. Steward, MD
NPI: 1801231295

Location:________________________________

Patient Payment Amount: ________________

Cash:____ Check:____ Check #:_______

Entered: WVSIIS _______

PracticeMate _______

Billed Date:____________________