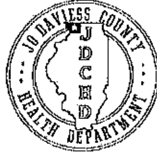

PAYMENT FORM

Date: ____________________

(Please print and complete all information. Parent or legal guardian please sign below)

Patient Name: ____________________ **M / F (Circle)** **Date of Birth:** ____________________

Address: ____________________ **City:** ____________________ **Phone:** ____________________

Parent Name: ____________________ **Dr. Name:** ____________________

School Name: ____________________

Recipient (Medicaid) I.D. Number ____________________ Managed Care Provider : ____________________

Received: ☐ Cash __________ ☐ Check __________

(Please advise if you will need a receipt for this service)

I have received a copy of the Jo Daviess County Health Department's Notice of Privacy Practice: ____________________

Site		Lot/Exp		Site		Lot/Exp.	
______	☐	DTap (Infanrix)	90700	______	☐	MMRV – ProQuad	90710
______	☐	Hep A – Havrix	90633	______	☐	Pediarix(DTAP-IPV-Hep B)	90723
______	☐	Hep B (Engerix)	90744	______	☐	RSV	90380/90381
______	☐	COVID-19/ 6m-11y	91321	______	☐	COVID-19 12y+- **91322**	
______	☐	Hib (Pedvax HIB)	90647	______	☐	Prevnar 20	90677
______	☐	HPV (Gardasil 9)	90651	______	☐	Men B (Bexsero)	90620
______	☐	IPV (Polio)	90713	______	☐	Rotarix	90681
______	☐	Kinrix Dtap-IPV	90696	______	☐	Influenza (Fluarix)	90686
______	☐	Meningitis (mcv4)	90619	______	☐	Tdap (Boostrix)	90715
______	☐	MMR	90707	______	☐	Varicella (Varivax)	90716

Education: Explained to client the following: VIS (Vaccine Information Statement) forms, all components of each vaccine, and answered clients questions and / or concerns.

Nurse's Signature: ____________________

I authorize the service provider to bill and release information to the IL Department of Public Aid for service received today if applies, otherwise I take full responsibility for payment.

Signed: ____________________ ***Date:*** ____________________

--- CONTINUED ON THE BACK SIDE ---

Screening Checklist for Contraindications to Vaccines for Children and Teens

PATIENT NAME ______________________________

DATE OF BIRTH ____/____/____ (month / day / year)

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Is the child sick today?	☐	☐	☐
2. Does the child have allergies to medicine, food, a vaccine component, or latex?	☐	☐	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Does the child have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, a cochlear implant, or a spinal fluid leak? Is he/she on long-term aspirin therapy?	☐	☐	☐
5. For children age 2 through 4 years: Has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐	☐	☐
6. For babies: Have you ever been told that the child had intussusception?	☐	☐	☐
7. Has the child, a sibling, or a parent had a seizure; has the child had a brain or other nervous system problem?	☐	☐	☐
8. Does the child have an immune-system problem such as cancer, leukemia, HIV/AIDS?	☐	☐	☐
9. In the past 6 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs to treat rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	☐	☐	☐
10. Does the child's parent or sibling have an immune system problem?	☐	☐	☐
11. In the past year, has the child received immune (gamma) globulin, blood/blood products, or an antiviral drug?	☐	☐	☐
12. Is the child/teen pregnant?	☐	☐	☐
13. Has the child received vaccinations in the past 4 weeks?	☐	☐	☐
14. Has the child ever felt dizzy or faint before, during, or after a shot?	☐	☐	☐
15. Is the child anxious about getting a shot today?	☐	☐	☐

FORM COMPLETED BY ______________________________ DATE __________

FORM REVIEWED BY ______________________________ DATE __________

Did you bring your immunization record card with you? yes ☐ no ☐

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.