MIDLAND COUNTY HEALTH DEPARTMENT
CONFIDENTIAL CLIENT INFORMATION

It is your responsibility to check with your health insurance company regarding coverage of specific vaccines. You can refer to our website for a list of insurance companies that we participate with. Payment is due at the time of service. We accept cash, check, Visa, MasterCard and Discover. You will be provided with a detailed receipt at the time of service for your insurance company or personal record. Most HSA accounts are not accepted.

Name:____________________ DOB:____________ Age:______ Client ID:____________

Gender:______ SS#________________ Last Name at Birth____________________

Address:____ Home Phone: ( )__________

Do you have an E-Mail Address? ______________________________ Cell Phone: ( )__________

What is your Ethnicity? Circle one: Hispanic, Non-Hispanic

What is your Race? Circle one: White, American Indian, African American, Alaskan Native, Asian, Native Hawaiian, or Pacific Islander

What is your preferred language?__________________

Change of Address: ______________________________________
I have read and verify that the above address is correct. Client's Initials______

Check one of the following

________ **Enrolled in Medicaid**
________ **Enrolled in Medicare**
________ **No health insurance**
________ **Health Insurance with immunization coverage** ***(you may be responsible for the cost of the vaccines/admin. fees at the time of service. You will be given a receipt to submit to your insurance carrier).***
________ **Health insurance but immunizations not covered**
________ **American Indian or Alaskan Native**

If Employer Is Paying, Provide Employer's Name____________________________

I verify that the above information is accurate

____
Client, Custodial Parent or Guardian Name (Please Print)

____
Client, Custodial Parent or Guardian Signature **(Today's Date)**

____
Clerks Initials

Midland County Health Department
Consent for Services and Release of Information

Client Name:______________________________________ DOB:____________ Age:_____

Midland County Health Department, its employees or agents may provide applicable services, examination and/or diagnostic testing or treatment. These services are provided confidentially, on a voluntary basis, without my being forced to accept any services or medications.

I understand that information from my record may be shared with the members of my treatment team. My treatment team will be determined by the services I receive, and may include, but is not limited to, a nurse, nurse practitioner, or doctor. In the event of an infestation or infection of a school-aged child, my child's school may be contacted. Childhood immunizations may be shared with the Michigan Childhood Immunization Registry. Any other release of information will require a specific release, signed by the client, custodial parent or guardian, unless the information is otherwise legally required.

I understand that I do not need to receive family planning services to get other services or support from the health department.

Midland County Health Department may release, either verbally or in writing, information contained in my medical, social, or educational records, including HIV, AIDS, or AIDS related information, as is necessary for the authorization and payment of bills for professional services.

I understand that I am responsible for charges due the Health Department and that payment is expected at the time of service.

If a Health Department employee is exposed to blood or body fluids by puncture, or consent to open skin or mucus membrane, the client's blood may be tested for HIV and other infectious diseases without further consent.

As a partner in my health care, I understand that participation and follow through is expected. Services may be terminated due to noncompliance. Examples of noncompliance are: not being at home two times for scheduled home visits, failure to pay fees for which I am responsible, or failure to follow a prescribed treatment.

This authorization will continue in effect through the duration of service associated with this admission or condition, up to one year, or until revoked in writing.

Print Name of the Person authorizing consent:

____

Custodial Parent, Guardian or Client (circle one)______________________________________

Signature:____**Today's Date**____________

Clerk's Initials____________

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 medications, 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 lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Is he/she on long-term aspirin therapy?	☐	☐	☐
5.	If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐	☐	☐
6.	If your child is a baby, have you ever been told he or she has had intussusception?	☐	☐	☐
7.	Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐	☐	☐
8.	Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
9.	Does the child have a parent, brother, or sister with an immune system problem?	☐	☐	☐
10.	In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	☐	☐	☐
11.	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?	☐	☐	☐
12.	Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐	☐
13.	Has the child received vaccinations in the past 4 weeks?	☐	☐	☐

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.

Midland County
Department of Public Health

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I was provided with a copy of the Midland County Department of Public Health Notice of Privacy Practices.

Patient Name (Print)	Patient Signature	Date

If completed by a patient's personal representative, please print and sign your name in the space below

Personal Representative (Print)	Personal Representative's Signature	Date

Relationship

For Midland County Department of Public Health use only

Complete this section if this form is not signed and dated by the patient or patient's personal representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of Midland County Department of Public Health Notice of Privacy Practices Acknowledgement, but was unable for the following reason:

Employee name	Date

This form should be placed in the patient's medical record