CLIENT INFORMATION FORM - SCHOOLS

PATIENT INFORMATION

Patient #:________________________

Name (Last): ____ First: ____ Middle: ___________________________

Gender: ☐ Female ☐ Male Date of Birth: _________/_________/_________ Age: ___________ Phone: ____________________________

Mailing Address: ____ City: __________________________ State: _________________ Zip: ____________

Race: ☐ White ☐ Hispanic ☐ Black ☐ Asian Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Unknown

☐ Other: _____________________________________

PARENT/GUARDIAN INFORMATION

☐ Mother ☐ Father ☐ Other: ____

Name (First): ____ Middle: ______________________________ Last: ____

Mailing Address: ____ City: ____________________________ State: _________________ Zip: _________________

Phone: ____

INSURANCE

☐ None

Primary Medical Insurance:	Secondary Medical Insurance:
Insurance Company Name:	Insurance Company Name:
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy #:	Policy #:
Group #:	Group #:

HEALTH HISTORY

1. Is the person being vaccinated sick today?	☐ Yes	☐ No	☐ Not Sure
2. Has the person to be vaccinated ever had a serious reaction to the influenza vaccine in the past?	☐ Yes	☐ No	☐ Not Sure
3. Has the person to be vaccinated ever had Guillain-Barre syndrome (a type of temporary, severe muscle weakness), seizures or neurological disorders?	☐ Yes	☐ No	☐ Not Sure
4. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine?	☐ Yes	☐ No	☐ Not Sure

PLEASE READ THE FOLLOWING AND INITIAL BOXES

☐ I acknowledge that I was given an opportunity to read/obtain the CDH Notice of Privacy Practices and Financial Policy which can be found at: https://www.cdh.idaho.gov/hl-immunizations-beforeyourappointment.php

☐ Participation in and withdrawal from Idaho's Immunization Reminder Information System (IRIS) is voluntary. Call Idaho Immunization Program at 208-334-5931 to opt-out or withdraw. If you do not opt-out of IRIS in writing, your child's immunization records will be stored in the registry.

☐ I give consent for my child to receive the influenza vaccine from Central District Health.

Parent/Guardian Signature: ____ **Date:** __________________________ **Nurse:** ___________________________