

Today's Date \_\_\_\_\_  
 Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Mailing Address \_\_\_\_\_ Current school \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
 Parents \_\_\_\_\_ Mother's Maiden Name \_\_\_\_\_  
 Is the individual Hispanic or Latino? YES NO  
 Race: White American Indian more than one race other/unknown

**If you have insurance please call them to verify immunization coverage prior to completing this form –Thank You.** RCHD is not responsible to inform you of what your insurance will or will not cover. You will be responsible for any balance.

Determining VFC

Do you have health insurance that covers vaccines Yes or No  
 Do you qualify for IHS (Indian Health Service) Yes or No  
 Or other federally funded insurance  
 Is your child enrolled in Healthy Montana Kids Plus (Medicaid) Yes or No

**Cost & Method of Payment**

*If you do not have insurance, qualify for IHS, or your insurance does not cover vaccines the cost is \$21.32 per shot.*

**Please photocopy front and back of insurance card and bring with form**

The RCHD **only bills the following insurances**

- \*Healthy Montana Kids Plus (Medicaid)
- \*Healthy Montana Kids (Chips)
- \*EBMS
- \*Cigna
- \*BC/BS
- \*Pacific Source

If you have health insurance that covers immunizations and it is not on the list of insurances that we bill, the cost per shot is listed below. Payment is required at the time of service and a charge sheet will be provided for you to submit to your insurance for reimbursement purposes.

TDaP	HeptA	Meningococcal	HPV	Varicella	Flu	Flu Mist
\$61.50	\$38.50 per vaccine (2 series vaccine)	\$130.50	\$191.50 per vaccine (3 series vaccine)	\$126.50	\$32.00	\$43.00

\*\*Please make payment to **RICHLAND COUNTY HEALTH DEPARTMENT OR RCHD**

I give permission for Richland County Health Department to enter my or my child's vaccine information into the electronic statewide immunization registry. This information will only be shared with health care providers and schools as necessary.

Client or Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please fill out reverse side**

I:\FORMS\Mass flu clinic\RCHD GENERAL & FORMS\school immunizations2015.pub

Richland County Health Department  
 1201 West Holly Suite #1  
 Sidney MT, 59270  
 406-433-2207

1. Is the person to be vaccinated sick today?
2. Does the person to be vaccinated have an allergy to eggs or to a component of the influenza vaccine?
3. Has the person to be vaccinated ever had a serious reaction to the influenza vaccine in the past?
4. Is the person to be vaccinated younger than age 2 years or older than age 49 years?
5. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), or anemia or another blood disorder?
6. If the person to be vaccinated is a child age 2 through 4 years, in the past 12 months, has a healthcare provider ever told you that he or she had wheezing or asthma?
7. Does the person to be vaccinated have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs?
8. Is the person to be vaccinated receiving antiviral medications?
9. Is the child or teen to be vaccinated receiving aspirin therapy or aspirin-containing therapy?
10. Is the person to be vaccinated pregnant or could she become pregnant within the next month?
11. Has the person to be vaccinated ever had Guillain-Barre syndrome?
12. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)?
13. Has the person to be vaccinated received any other vaccinations in the past 4 weeks?
Form completed by: _____ Date: _____ Form reviewed by: _____ Date: _____ Technical content reviewed by the Centers for Disease Control and Prevention www.immunize.org/catg.d/p4067.pdf Item #P4067 (8/12) Immunization Action Coalition 1573 Selby Ave. St. Paul, MN 55104 (651) 647-9009 www.immunize.org www.vaccineinformation.org