Southwest Utah Public Health Department – Intake Form

All information is strictly confidential - All items MUST be completed

(*Please Print*)

Patient Last Name	First Name	Middle	Date of Birth (mm/dd/yyyy)	Age

Race	Ethnicity	Emergency Contact (Name and Phone Number)	Gender
☐ White ☐ Black ☐ Asian ☐ American Indian ☐ Alaskan Native ☐ Pacific Islander	☐ Hispanic ☐ Non Hispanic		☐ Male ☐ Female

Address	Unit/Apt	City	State	Zip code

Primary Phone #		Best Form of Contact		Email:
	☐ Cell ☐ Home ☐ Work		☐ Phone Call ☐ Text ☐ Email	Please contact me about upcoming events and services ☐Opt-in ☐Opt-out

Primary Health Insurance	Policy #	Policy Holder (Exact Name listed on Card)

Insurance Policy Holder Date of Birth (mm/dd/yy)	Relationship to Patient	Address of Policy Holder

↓ Sign Here

I certify that the information I have provided is true and accurate. I have been given a copy and have read, or have had explained to me, the information contained in the important Vaccine Information Statements. I have had a chance to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccines and request that the vaccines indicated be given to the person named above for whom I am authorized to make this request. I agree that this information may be shared with schools, day care centers, health care providers, others when deemed medically necessary, and the Utah State Immunization Registry.

I HEREBY RELEASE SOUTHWEST UTAH PUBLIC HEALTH DEPARTMENT, AND ITS EMPLOYEES, FROM ALL CLAIMS ARISING FROM SUCH IMMUNIZATIONS. I UNDERSTAND THE BILLING OF MEDICAL INSURANCE DOES NOT GUARANTEE PAYMENT AND THAT I AM RESPONSIBLE FOR ANY UNPAID BALANCE.

We are required to inform you of our privacy practices for the information we collect and keep about you. I have been given a copy of the Health Department's Notice of Privacy Practices and have had an opportunity to ask questions about how my information may be used.

X Signature _____ Print Name: _____ Date: _____

Relationship to Patient: ☐ **Self** ☐ **Parent** ☐ **Legal Guardian** ☐ **Other** _____

Immunization Screening Questionnaire	**Yes**	**No**	**Don't know**
1. Is the individual sick today?			
2. Does the individual have allergies to medicine, food, a vaccine component, or latex? List _____			
3. Has the individual had a serious reaction to a vaccine in the past? Describe _____			
4. Does the individual have a long-term health problem with heart, lung (including asthma), kidney, liver, nervous system, or metabolic disease (e.g., diabetes), a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are they taking regular aspirin or salicylate medication?			
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 the child had intussusception?			
7. Has the individual, a sibling, or a parent had a seizure; has the individual had a brain or other nervous system problem?			
8. Has the individual ever been diagnosed with a heart condition (myocarditis or pericarditis) or have they had Multisystem Inflammatory Syndrome (MIS-C) after an infection with the virus that causes COVID-19?			
9. Does the individual have an immune-system problem such as cancer, leukemia, HIV/AIDS?			
10. In the past 6 months, has the individual 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?			
11. Does the individual's parent or sibling have an immune system problem?			
12. In the past year, has the individual received immune (gamma) globulin, blood/blood products, or an antiviral drug?			
13. Is the individual pregnant?			
14. Has the individual received vaccinations in the past 4 weeks? List _____			
15. Has the individual ever felt dizzy or faint before, during, or after a shot?			
16. Is the individual anxious about getting a shot today?			

Tuberculosis (TB) Test Screening Questionnaire	**Yes**	**No**	**Don't know**
Has the individual had a previous TB skin test: If so, date of last test _____ and results _____			
Has the individual ever had a QuantiFERON (QFT) blood test to check for TB disease? If yes, what were the results?			
Has the individual ever been diagnosed with latent or active tuberculosis?			
Has the individual had treatment for tuberculosis?			
Has the individual received any vaccinations in the past 4 weeks?			
Has the individual ever received BCG (tuberculosis) vaccine? (*not administered in the U.S.*)			

For Health Department Use ONLY

Patient Name _____ **Patient ID _____**

PPD Placed Date _____ Time: _____ JHP Aplisol 5 TU/0.1ml Lot # _____ **Site: LFA RFA** Nurse: _____

PPD Read Date: _____ Time: _____ mm Results: _____ Results read by: _____

☐ TB Screening Questionnaire Nurse: _____ ☐ QFT Referral Nurse: _____ Referred to: _____

District Vaccine

Vaccine		Vaccine
Adacel 10–64 yrs		Peds Hep A 12mo–18yrs
Adult Hep A 19 yrs+		Peds Hep B 0 – 19 yrs
Adult Hep B 20 yrs+		Pentacel 2 mo – 4 yrs
Bexsero 10-25 yrs		PF Flu 6 mo & up
Boostrix 10 yrs +		Prevnar 13 6 wks+
DTaP 2 mo – 6 yrs		Prevnar 20 6 wks+
FluBlok 50 yrs+		Quadracel 4– 6 yrs
Fluzone MD 6 mo+		Rabies
Heplisav-B 18 yrs+		Rotarix 6 wks – 7 mo
HIB 2 mo – 4 yrs		Rotavirus 6 wks–7 mo
HD Flu 65 yrs+		RSV - Arexvy / Abrysvo 60 yrs+
IPV (Polio) 6 wks+		Shingrix 50 yrs+
MenQuadfi 2 yrs+		TicoVac 12 mo+
MMR (Live) 12 mo+		TD 7 yrs & up
Moderna 6m-11y		Twinrix 18 yrs+
Moderna 12 yrs+		Varicella (Live) 12 mo+
Pediarix 2 mo–6 yrs		

VFC Vaccine (through age 18y)

Vaccine		Vaccine
Adacel 10–64 yrs		Pediarix 2 mo–6 yrs
Bexsero 10-25 yrs		Peds Hep A 12mo–18yrs
Beyfortus ≤ 2 yrs		Peds Hep B 0 – 19 yrs
Boostrix 10 yrs +		Pentacel 2 mo – 4 yrs
DTaP 2 mo – 6 yrs		PCV 13 / 15 / 20 6 wks+
Fluzone MD 6 mo+		Quadracel 4– 6 yrs
HIB 2 mo – 4 yrs		Rotarix 6 wks – 7 mo
IPV (Polio) 6 wks+		Rotavirus 6 wks–7 mo
MenQuadfi 2 yrs+		TicoVac 12 mo+
MMR (Live) 12 mo+		TD 7 yrs & up
MMRV (Live) 12 mo+		Varicella (Live) 12 mo+
Moderna 6m-11y		Vaxelis 6wks-4yrs
Moderna 12 yrs+		

Special Projects Vaccine (19+)

Vaccine		Vaccine
Adacel 10–64 yrs		Heplisav-B 18 yrs+
Adult Hep A 19 yrs+		Moderna 12 yrs+

Medicare Procedures

Vaccine		Vaccine
Adult Hep B		Prevnar 13
Flu Reg		Prevnar 20
FluBlok		Moderna 12 yrs+
Heplisav-B		RSV - Arexvy / Abrysvo 60 yrs+
HD Flu 65+		

Travel Vaccines

Vaccine		Vaccine
Japanese Enc 2mo+		Typhoid Vi 2yrs+
Typhoid Oral 6yrs+		Yellow Fever 9mo-60yrs

Labs & Screenings

A1C		Blood Glucose
Body Mass Index (BMI)		Blood Pressure
Lipid Panel		Pre-diabetes Screening

Vaccine	Lot #	Dose	Category	Site	Payment Information
					□ Cash _____ □ Card _____
					□ Check # _____ □ Voucher
					Notes:
					RN:

For Health Department Use ONLY:

Gross Monthly Income: _____ # of Family Members: _____

PFR: _____ RN: _____