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	Gender ☐ Male ☐ Female

Race ☐ White ☐ Black ☐ Asian ☐ American Indian ☐ Alaskan Native ☐ Pacific Islander	Ethnicity ☐ Hispanic ☐ Non Hispanic	Emergency Contact (name, phone number, relationship)

Address	Unit/Apt	City	State	Zip code

Primary Phone #	☐ Cell ☐ Home ☐ Work	Best Form of Contact	☐ Phone Call ☐ Text ☐ Email	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

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 ever had a serious reaction to a vaccine in the past, including feeling dizzy or fainting? 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. Has the individual, a sibling, or a parent had a seizure; has the individual had a brain or other nervous system problem?			
6. 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?			
7. Does the individual have an immune-system problem such as cancer, leukemia, HIV/AIDS?			
8. 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?			
9. In the past year, has the individual received immune (gamma) globulin, blood/blood products, or an antiviral drug?			
10. Is the individual pregnant?			
11. Has the individual received vaccinations in the past 4 weeks? List: ______________________________			
12. For babies: Have you ever been told the child had intussusception?			

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.*)			

Sign Here →

I certify that the information I have provided is true and accurate. I consent to the services being requested.

For vaccination visits: 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 SERVICES.
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 offered 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** ______________________