Cumberland County Health Department
VACCINE REGISTRATION FORM (0-18 years of age)

PATIENT INFORMATION

Patient's First Name	Middle Name	Last Name	SSN

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name(s))	Birth Date MM/DD/YYYY / /	Age	Sex ❑ M ❑ F

Race: ❑ Asian/Pacific Islander/Other ❑ Black or African American ❑ Caucasian or White ❑ Native American/Alaska Native ❑ Hawaiian ❑ Unknown or Other

Ethnicity: Hispanic/Latino?: ❑ Yes ❑ No

Current Address	City	State	ZIP Code

Cell Phone No. ( )	Home Phone No. ( )	Preferred Language

Where has the child previously received immunizations?

GUARDIAN

Name of Guardian	Relationship to Patient	Phone No.	Additional Phone No. ( )

DOB (MM/DD/YYYY)	SSN:	Address if different than patient	

BILLING

Primary Insurance Carrier

Insurance Co. Name _____ ID#:_____ Group#_____

Policy Holder (Name): _____ Policy Holder's Birthdate: __/__/____

Patients relationship to policy holder (child, spouse, self) _____

Secondary Insurance Carrier

Insurance Co. Name _____ ID#:_____ Group#_____

Policy Holder (Name): _____ Policy Holder's Birthdate: __/__/____

Patients relationship to policy holder (child, spouse, self) _____

By my signature below, I authorize the Cumberland County Health Department to bill any of the medical payers as indicated above and provide necessary information to process claims. I authorize payment of medical benefits to the Cumberland County Health Department for services rendered and I understand I will be responsible for payment of charged deemed "uncovered" by my health insurance.

All records of services rendered are considered confidential. This constitutes advance notice to you, the beneficiary, that if all program requirements are met by the Cumberland County Health Department and payment is not made by your Health Insurance, you may be responsible for the charges. You may also be responsible for charged if you fail to inform the Health Department of Insurance coverage in a timely manner. The undersigned has read the above authorization and understands the same. I certify that the information provided on this page is true and correct to the best of my knowledge. I acknowledge that I was offered a copy of the CCHD Privacy Policy dated 9-2016.

SIGNATURE _____ **DATE** _____

IMMUNIZATION SCREENING QUESTIONNAIRE

1.	Is the child to be vaccinated currently sick or experiencing a high fever? If yes, please explain:	❑ Yes ❑ No
2.	Does the child to be vaccinated have allergies to medications, food, a vaccine component, or latex? If yes, please list:	❑ Yes ❑ No
3.	Has the child had a serious reaction to a vaccine in the past? If yes, please explain:	❑ Yes ❑ No
4.	Has the child to be vaccinated ever had Guillain-Barré syndrome (neurological disoder)?	❑ Yes ❑ No
5.	Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	❑ Yes ❑ No
6.	Is the child to be vaccinated planning to travel out of the United States? If so, when and where?	❑ Yes ❑ No

Reviewed by: _____ Date: _____

VACCINE CONSENT

I have been offered a copy of the Vaccine Information Statement(s) (VIS) checked below. I have read, had explained to me, and understand the information in the VIS(s). I ask that the vaccine(s) checked below be given to me or to the person named below for whom I am authorized to make this request. I consent to inclusion of this immunization data in the North Carolina Immunization Registry for myself or behalf of the person named on this form.

❑ DTaP	❑ Polio/IPV	❑ DTaP/IPV (Combo)	❑ Hepatitis A	❑ MMR	❑ Gardasil 9 (HPV)	❑ Tdap
❑ Td	❑ Prevnar 13	❑ DTaP/Hib/IPV (Pentacel)	❑ Hepatitis B (HepB)	❑ Varicella (V)	❑ Meningococcal Quad	❑ Influenza (flu)
❑ Hib	❑ Rotavirus	❑ DTaP/IPV/HepB (Pediarix)	❑ PPSV23	❑ MMR-V (Combo)	❑ Meningococcal B	❑ Typhoid

Signature of Patient or Legal Parent/Guardian: Date:

NURSE DOCUMENTATION (FOR NURSE USE)

VACCINE	EXT	SITE	ROUTE	VIS DATE	MANUFACTURER, LOT #, EXPIRATION DATE
DTaP / Td / Tdap	RT LT	Deltoid Vastus Lat	IM	Documented In NCIR	
DTaP/IPV (Kinrix)	RT LT	Deltoid Vastus Lat	IM	Documented In NCIR	
DTaP/HepB/IPV (Pediarix)	RT LT	Deltoid Vastus Lat	IM	Documented In NCIR	
DTaP/Hib/IPV (Pentacel)	RT LT	Deltoid Vastus Lat	IM	Documented In NCIR	
Hepatitis A	RT LT	Deltoid Vastus Lat	IM	Documented In NCIR	
Hepatitis B	RT LT	Deltoid Vastus Lat	IM	Documented In NCIR	
Hib	RT LT	Deltoid Vastus Lat	IM	Documented In NCIR	
HPV (Gardasil 9)	RT LT	Deltoid	IM	Documented In NCIR	
Fluzone 6 months+	RT LT	Deltoid Vastus Lat	IM	Documented In NCIR	
MCV4/MPSV4 (Menveo/Menactra)	RT LT	Deltoid	IM	Documented In NCIR	
Meningococcal B	RT LT	Deltoid	IM	Documented In NCIR	
MMR	RT LT	Thigh	SC	Documented In NCIR	
MMRV (ProQuad)	RT LT	Upper Arm Thigh	SC	Documented In NCIR	
PCV13 (Prevnar 13)	RT LT	Deltoid Vastus Lat	IM	Documented In NCIR	
Polio/IPV	RT LT	Deltoid Vastus Lat	IM	Documented In NCIR	
PPV23	RT LT	Deltoid Vastus Lat	IM	Documented In NCIR	
Rotavirus (Rotarix/RotaTeq)	PO	By Mouth	Oral	Documented In NCIR	
Varicella	RT LT	Upper Arm Thigh	SC	Documented In NCIR	
Typhoid	RT LT	Deltoid	IM	Documented In NCIR	

VACCINE ADMINISTRATOR

Signature: Date: