

Sherman County Health Department

Patient Information										
Patient's Last Name			Patient's First Name			Phone Number		Age	Birth Date	
Street Address				City		County	State		Zip Code	
Ethnicity ☐ Not Hispanic/Latino ☐ Hispanic/Latino		Race ☐ Caucasian/White ☐ American Indian/Alaskan Native ☐ Asian ☐ African American/Black ☐ Native Hawaiian/Other Pacific Islander ☐ Other Non-white						Gender ☐ Male ☐ Female		
Insurance										
Name of Insurance Company						Policy Number				
Insured's Name						Insured's DOB				
Immunization Screening Questionnaire										
1	Does the patient have allergies to medication, food, a vaccine component, or latex?							Yes	No	Unsure
2	Does the patient have any medical conditions that could affect vaccination? (such as: immunocompromising conditions, intussusceptions, Guillain-Barré Syndrome, or others)							Yes	No	Unsure
3	Has the patient ever felt dizzy or faint before, during, or after a shot?							Yes	No	Unsure
4	Is the patient pregnant or could become pregnant within the next one month?							Yes	No	Unsure
Vaccine Consent										
I acknowledge that I have been offered a copy of the Vaccine Information Statement(s) (VIS) for the vaccines being administered today. I have read, had explained to me, and understand the information in the VIS(s). I ask that the vaccines(s) checked below be given to me or to the person named above for whom I am authorized to make this request. I acknowledge that I have been provided SCHD's Notice of Privacy Practices with the effective date of August 30, 2013. I give permission for Sherman County Health Dept to provide services and/or treatment for myself or my child and I understand that I am financially responsible for										
Signature					Relationship to patient			Date		

Vaccines to be Administered:		
	Vaccine	Code
☐	Influenza	90656 / 90471
☐	High dose Influenza	90662 G008
☐ Yes	☐ No	Is client VFC / VFA eligible?

For Staff Use Only

☐	Influenza	0.5ml	☐ R	☐ L	☐ Del	☐ Vas Lat	IM	1/31/2025
Labels								

Signature of Nurse