Missoula Public Health
City-County Health Department

Missoula City-County Health Department
HEALTH SERVICES
301 W Alder Street| Missoula, MT 59802-4123
PHONE | 406.258.4750
406.258.4745
FAX | 406.258.4913

CHECK LIST
Attachment B – 3rd Party Authorization Form

This form may be used if the parent/legal guardian is unable to accompany their child(ren) to Missoula City-County Health Department for Immunization Clinic Services and are authorizing another adult to bring in their child(ren). The parent/legal guardian must complete ALL of the following and present at the time of service:

☐ **Completely fill out and sign *Attachment B – 3rd Party Authorization Form***

☐ **Include a copy of a valid photo ID of the Parent/Legal Guardian completing the form**

☐ ***Registration form*: Complete page 1 and sign and date**

☐ **Include a copy of your child's insurance card (we do not accept Tricare/United)**

☐ ***Health History form*: Complete page 1 regarding the child's medical history**

☐ **Include current copy of your child's immunization record 2 ŦI·È ŜŏŘă ű2 нрупофн**

☐ **The Authorized 3rd Party Adult must bring a valid photo ID**

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Attachment B – 3rd Party Authorization Form

Please review the following information and authorization for immunizations or other clinic services when you cannot be present at the time of treatment.

I (we) have the legal right to designate 3rd party authorization to the following individual* to bring my child/dependent to MCCHD to receive services from the Outpatient Clinic:

_____

Last Name First Name MI Date of Birth
(* the authorized 3rd party individual must bring a photo ID)

Please select all services requested:

☐ Required vaccines to attend school or daycare

☐ Age-recommended vaccines

☐ PPD skin test

☐ Blood draw for immunization antibodies (MMR, Varicella, Hep B, rabies)

☐ Other clinic service (please specify):_____

Client information:

_____ / / _____

Last name First name MI Date of Birth

Parent/Legal Guardian Information:

_____ / / _____

Last name First name MI Date of Birth

_____ / / _____

Last name First name MI Date of Birth

Relationship to client (select one): ☐ Mother ☐Father ☐ Other:_____

☐ Legal Guardian/Authorized Representative (documentation must be provided)

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We understand that I (we) will be notified by telephone (at the contact number listed below) if other services are recommended, if there are questions or clarifications about medical history including immunizations, or in the event of an adverse reaction after receiving services.

Contact information for Parent/Guardian: phone #:_____

Alternate phone #:_____

Parental/Legal Guardian Consent for MCCHD Outpatient Immunization Clinic Services
I give permission for my child/dependent to be seen by nursing staff at MCCHD as indicated above. I understand that MCCHD will inform me of any emergency regarding my child/dependent by phoning my contact telephone listed above.

X_____
Signature of Parent/Legal Guardian* DATE

Release of Information:
I give permission for MCCHD Outpatient Immunization Clinic to request and/or share my child's/dependent's immunization record as needed for continuity of care with other medical providers, schools, and/or day care.

X_____
Signature of Parent/Legal Guardian DATE

***You must attach a copy of your photo ID (**driver's license, pass port etc)

This authorization expirations 14 days from the date of signature.

Form Date: 10/2015

Today's Date: _____

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406.258.474S
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REGISTRATION FORM

MR#:_____

Client demographic information:

Client Name (person receiving services): _____
(Please print): Last First MI
Other names you may have used: (such as maiden name): _____

Date of Birth: _____/_____/_____ *(mm/dd/yyyy)* Age: _____ Gender *(circle)*: Male Female

Mailing Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____ Medical Provider: _____

Home Phone: (____) _____-_____ Other Phone (____) _____-_____

Race/Ethnicity: ☐ White ☐ Asian/Pacific Islander ☐ Hispanic ☐ Black ☐ American Indian or Alaskan Native ☐ Multiracial ☐ Other

Parent/Guardian Name *(if patient under 18)* _____

Insurance Information:

☐ No Insurance ☐ Enrolled in HMK Plus/Medicaid ☐ Enrolled in HMK Plan (formally CHIP) ☐ Has health insurance that covers vaccines
☐ Has health insurance that *Does Not* pay for vaccines (not including high deductible or co-pays) ☐ Employer/Agency Paid_____
☐ Insurance for *Adults* that covers only certain vaccines or is capped at a certain amount ☐ Self-Pay (has insurance but does not want us to bill)
☐ Insurance for *Adolescent* that covers or partially covers vaccines, but the co-pay or deductible is too expensive for family to pay

Name of Insurance_____ ID# _____ Group# _____

Subscriber's name _____ DOB_____ Relationship to Patient _____

Acknowledgement and Consent:

Please check each of the following boxes:

1. ☐Consent to treat: I authorize Missoula City-County Health Department to administer treatment as deemed necessary for care of the patient named above. If applicable, I certify that I am the parent or legal guardian of the patient. I also certify that no guarantee or assurance has been made as to the results that may be obtained from the treatment.

2. ☐Assignment of Benefits: I authorize payment of medical benefits to Missoula City-County Health Department for services rendered. I understand that the patient/parent or responsible party is responsible for any unpaid balances. While we may bill your insurance company, you are solely responsible for knowing what is covered under your plan and are ultimately responsible for any balance due.

3. ☐Privacy Notice: I have reviewed a copy the Notice of Privacy Practices, which provides a description of information uses and disclosures. I may request a copy of the Notice of Privacy Practices for my own records.

4. ☐ ACCEPT imMTrax State Immunization Registry ☐ DECLINE imMTrax State Immunization Registry ☐N/A (no vaccines) today
(please read the following statement and check *accept* or *decline*): I authorize my health care provider and local public health agency to collect and enter my or my child's immunization records into the Department of Public Health and Human Services' immunization registry (imMTrax), a confidential computer system that contains immunization records. I understand that information in the registry may be released to local health departments, as well as my health care providers to assist in my or my child's medical care and treatment. In addition, information may be released to child care facilities and schools in which my child is enrolled to comply with state requirements. I understand that I can revoke this authorization and have my record removed at any time by contacting my local county health department.

Patient (Parent/Guardian) Signature: _____Date:_____
By signing this form, I agree that the information I provided is accurate and truthful and I agree with the acknowledgement and consent above.

OFFICE USE ONLY
All Information is complete and reviewed by Front Desk (initials):_____ Insurance Card Copied OR Verbally Verified in HDIS OR Web portal verified (circle one) OR N / A

Form Date: 10/2015

Today's Date: _____

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REGISTRATION FORM

Client Name:_____DOB:_____MR#:_____

The clinic RN will review this section with you:

Safety Acknowledgement and Waiver:

1. ☐ VIS: I have read or have had explained to me the information contained in the Vaccine Information Statement(s) about the disease(s) and the vaccine(s).
   ☐ N/A: I am not receiving vaccines today

2. ☐ Authorization: I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s), blood draw, TB test or other screening and request the vaccine(s), blood draw, TB test or other screening to be administered today to me or to the person named above for whom I am authorized to make this request.

3. I understand it is the policy of Missoula City-County Health Department's Outpatient Clinic and International Travel Clinic to recommend that all individuals who have received an injection, blood draw, or TB test remain in the reception area for at least 15 minutes after their procedure. This is a safety precaution to avoid possible problems associated with fainting or an allergic reaction:
   ☐ I DECLINE to wait 15 minutes ☐ I AGREE to wait 15 minutes

Client (Parent/Guardian) Signature: _____Date:_____
By signing this form, I agree that the information I provided is accurate and truthful and I agree with the acknowledgement and consent above.

Office use only:

Service(s) received today (check all that apply):

☐ Lice screening ☐ Pregnancy test ☐ Lead screening ☐Blood tests ☐ TB Test ☐ No services received

☐Other_____ ☐ Travel consult – see Risk Assessment form

☐ Vaccine(s) Administered ☐ No contraindications or precautions to vaccinations.

☐ Client DECLINES vaccines (list):_____

RN Notes: _____

_____

_____

_____

_____

_____

Reviewed by/ RN signature:_____ Date:_____

Form Date: 6/2015

Today's Date: _____

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SCREENING QUESTIONNAIRE

Client Name:_____DOB:_____MR#:_____

For Immunizations only: Please read carefully and check YES or NO. The nurse will discuss any YES responses with you.

A.	Please answer the following for the person receiving immunizations:	YES	NO
1.	Is the person getting the vaccine sick today?	☐	☐
2.	Has the person getting the vaccine ever had a serious reaction after receiving a vaccination?	☐	☐
3.	Does the person getting the vaccine have any long-term health problems such as lung disease, heart disease, kidney disease, metabolic disease, diabetes, asthma, anemia or other blood disorder, asplenia, or other health condition?	☐	☐
4.	Does the person getting the vaccine have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐
5.	In the past 3 months, has the person getting the vaccine taken medications that can weaken the immune system, such as Cortisone, Prednisone, Methotrexate or other steriods, anticancer drugs, TNF-alpha inhibitors such as Enbrel, Remicade, Humire, Raptivea, Orencia	☐	☐
6.	In the past year, has the person getting the vaccine received a transfusion of blood or blood products, been given immune (gamma) globulin, currently getting or recently had radiation treatment, or taken an anti-viral drug (such as Acyclovir, Famciclovir, Valacyclovir)	☐	☐
7.	Has the person getting the vaccine had a seizure or other brain or nervous system problem (such as Guillain-Barre Syndrome, encephalitis)?	☐	☐
8.	Has the person getting the vaccine had any vaccines in the last 4 weeks?	☐	☐
9.	Please list any allergies (food, medications, vaccine component, or latex) and the type of reaction: ☐ No known allergies		
10.	Please list your current medications (or attach list): ☐ None		
B.	Additional Questions for Females	YES	NO
1.	Is the person getting the vaccine pregnant or breastfeeding or is there a chance of becoming pregnant or breastfeeding during the next month?	☐	☐
C.	Additional Questions for Children (0-18 years)	YES	NO
1.	If the child getting the vaccine is an infant, have you ever been told he/she has had problems with their bowels (such as intussusception)?	☐	☐
2.	Has the child, sibling, or parent ever had a seizure?	☐	☐
3.	If the child is between ages 2-4 years, has a health care provider told you that the child had wheezing or asthma in the past 12 months?	☐	☐
4.	Is the child on long-term aspirin therapy?	☐	☐

Office use only:

Reviewed by (RN initials):_____ If YES response(s): ☐ see nurse notes ☐ see HDIS medical notes

Form Date: 6/2015

Today's Date: _____

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SCREENING QUESTIONNAIRE

Client Name:_____DOB:_____MR#:_____

Tuberculosis Testing Only:		Yes	No
1.	Reason for test (circle one): employment – school – volunteer – overseas travel – immigration – foreign born – exposure contact – other:_____.		
2.	Have you ever had a positive TB test result in the past?	☐	☐
3.	Have you had any live virus vaccines in the past 4 weeks (such as MMR, Varicella, Yellow Fever, Zostavax)?	☐	☐
4.	Have you had a viral illness such as influenza or chickenpox recently?	☐	☐
5.	Have you ever been in contact with anyone with active TB disease?	☐	☐
6.	Do you have any illness that may suppress your immune system, or are you on any immunosuppressive medications?	☐	☐
7.	Are you able to return to the clinic in 3 days to get your test read? If you miss your return day, you will be marked as "no show" and you will have to have a new test placed which includes a new fee.	☐	☐

For TB Testing only: Please read carefully and check YES or NO. The nurse will discuss any YES responses with you.

Office use only:

Reviewed by (RN initials):_____ If YES response(s): ☐ see nurse notes ☐ see HDIS medical notes