Form 7/17

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

CHECK LIST: 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).

Parent/legal guardian must:

☐ **Complete and sign *3rd Party Authorization Form***

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

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

☐ **Include a copy of your child's insurance card (front and back)**

☐ **Verify with your insurance company that Missoula City-County Health Department is "in-network" and routine vaccines are covered services**

☐ ***Screening Questionnaire*: Complete page 1 regarding the child's medical history if receiving immunizations and complete page 2 if receiving Tuberculosis screening**

☐ **Include current copy of your child's immunization record or have records faxed to 406-258-4913 ATTN Immunizations**

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

☐ **Send all of the above information with the authorized 3rd party person presenting for the visit with your child**

If you have questions, please call 258-3363

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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: 07/2017

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REGISTRATION FORM

Date:_____

Client demographic information: (Please print)

Client Name (person receiving services): _____
Last First MI

Other names used: (such as maiden name):_____ Gender *(circle)*: Male Female

Date of Birth*:* _____/_____/_____ *(mm/dd/yyyy)* Age: _____ *Primary Care Physician*: _____

Mailing Address: _____ Apt. #: _____

City: _____County: _____ State: _____ Zip Code: _____

Home Phone: (____) _____-_____ Other Phone (____) _____-_____ May we leave a detailed message on your phone? Yes / No

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race: ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ Black/African-American ☐ American Indian or Alaska Native ☐ Multiracial ☐ Other

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

Relationship to client: ☐ Mother ☐ Father ☐ Legal guardian ☐*Other (specify): _____ * must provide 3rd party authorization

Insurance Information: Please check one box and provide your insurance card(s)

☐ No Insurance *v03/v23/v04* ☐ Enrolled in HMK Plus *v02/v04* ☐ Enrolled in HMK Plan (CHIP) *v01* ☐ Has health insurance that covers vaccines *v01*

☐ Has health insurance that *Does Not* pay for vaccines (not including high deductible or co-pays) *v01/v05/v23* ☐Employer/AgencyPaid_____ *v01*

☐ Insurance for *Adults* that covers only certain vaccines or is capped at a certain amount *v01/v23* ☐ Self-Pay (has insurance but does not want us to bill) *v01*

☐ Insurance for *Adolescents* that covers or partially covers vaccines, but the co-pay or deductible is too expensive for family to pay *v25/v01*

Primary Insurance_____ ID# _____ Group# _____

Subscriber's name _____ DOB_____ Relationship to Patient _____

Do you have a Secondary Insurance: ☐ Yes ☐ No If yes, please give your card to front desk person

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. I understand that any unpaid balance may be sent to a collection agency. Missoula City-County Health Department reserves the right to pursue legal action and you accept responsibility for any attorney's fees and court costs incurred if legal action is pursued.

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

(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 Patagonia OR Web portal verified OR N / A

Form Date: 6/2017

Missoula Public Health
City-County Health Department

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OFFICE USE: MR#: _____

SCREENING QUESTIONNAIRE - IMMUNIZATIONS

Client Name:_____DOB:_____Today's Date:_____

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

Please answer the following for the person receiving immunizations:	
1.	Please list any allergies and the type of reaction (check all that apply): ☐ No known allergies ☐ Eggs ☐ Baker's Yeast ☐ Gelatin ☐ Latex ☐ Thimerosal ☐ Streptomycin ☐ Neomycin ☐ Casein ☐ Other (describe):
2.	Please list your current medications (or attach list): ☐ None
3.	Does the person getting the vaccine have any of the following health problems (check all that apply): ☐ None ☐ lung disease (ex: COPD, asthma, emphysema) ☐ liver disease (ex: cirrhosis, Hepatitis) ☐ alcoholism ☐ renal failure/dialysis ☐ metabolic disease ☐ diabetes ☐ asplenia ☐ cerebrospinal fluid leak ☐ cochlear implant ☐ heart disease (congestive heart failure, cardiomyopathies) ☐ seizures ☐ Guillain-Barre Syndrome ☐ encephalitis ☐ anemia or other blood disorder (sickle cell disorder, thrombocytopenia) ☐ other health condition (please describe):
4.	Does the person getting the vaccine have any immune system problems (check all that apply): ☐ No ☐ cancer ☐ leukemia ☐ HIV/AIDS ☐ organ or stem cell transplant ☐ Any other immune system problem (please describe):
5.	Does the person getting the vaccine (check all that apply): ☐ No ☐ smoke cigarettes ☐ use IV drugs
6.	Females only: Is the person getting the vaccine pregnant or breastfeeding or is there a chance of becoming pregnant during the next month? ☐ N/A ☐ No ☐ Yes (please describe):
7.	Children 0-18 years only: has the child, a sibling or parent ever had brain or other nervous system problem such as seizures or swelling of the brain? ☐ N/A ☐ No ☐ Yes (please describe):
8.	Infants only: have you ever been told that the infant getting the vaccine has had problems with their bowels (such as intussusception)? ☐ N/A ☐ No ☐ Yes (please describe):
9.	Is the person getting the vaccine sick today? ☐ No ☐ Yes (please describe):
10.	Has the person getting the vaccine ever had a serious reaction after receiving a vaccination? ☐ No ☐ Yes (please describe):
11.	Has the person getting the vaccine had any vaccines in the last 4 weeks? ☐ No ☐ Yes (please describe):
12.	In the past 3 months, has the person getting the vaccine ever (check all that apply): ☐ No ☐ Had treatment with anticancer drugs ☐ Taken medications that can weaken the immune system such as steroids (ex: Prednisone) or biologics (ex: Enbrel, Humira) for the treatment of certain conditions like rheumatoid arthritis, Crohn's disease or psoriasis
13.	In the past year, has the person getting the vaccine ever (check all that apply): ☐ No ☐ Received a transfusion of blood or blood products ☐ Received immune (gamma) globulin ☐ Currently getting or recently had radiation treatment ☐ Taken an anti-viral drug (such as Acyclovir, Famciclovir, Valacyclovir) ☐ Children 0-18 years on long-term aspirin therapy

_____

Signature of Client/Parent/Guardian completing this form Date

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OFFICE USE: MR#: _____

SCREENING QUESTIONNAIRE – TUBERCULOSIS SCREENING

Client Name:_____DOB:_____Today's Date:_____

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

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.	Are you currently sick or recently had a bacterial or viral infection?	☐	☐
5.	Have you ever been in contact with anyone with active TB disease?	☐	☐
6.	Have you ever had BCG? If yes, when:	☐	☐
7.	Do you have any illness that may suppress your immune system, or are you on any immunosuppressive medications?	☐	☐
8.	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.	☐	☐

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Client Name:_____DOB:_____

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:_____