DPH Immunization Program

Telephone: 236-8745/8780/8781/8682/8708

Patient Encounter Form

Program Administration Site:______________________ **Date:** ___/___/___ **Time:** ____:____

DEMOGRAPHICS

1. Name of Patient: ______________________
2. DOB: ____/____/____ 3. Age ______ 4. Gender: M / F
5. Contact No.: ______________________
6. School: ______________________
7. Grade: ______________________

HOSPITAL ID# ______________________

VILLAGE: ______________________

MAILING ADDRESS: ______________________

EMAIL ADDRESS: ______________________

HEALTH INSURANCE INFORMATION ***note: check all that applies to you***

1. a. [ ] Medicaid b. [ ] Uninsured c. [ ] Underinsured d. [ ] American Indian/ Alaskan Native e. [ ] Private

HEALTH SCREENING

1. Allergies :Yes / No *(if yes, specify)* ______________________
2. Pregnant :Yes / No / Not Sure
3. Chronic Illness :Yes / No *(if yes, specify)* ______________________
4. History of Chicken Pox :Yes / No Year ______________________
5. Temperature :Not Done *If done* : ________
6. Weight :Not Done *If done* : weight ________

COMMENTS: ______________________

VACCINATION

A copy of the appropriate Centers for Disease Control and Prevention Information Material(s) has been provided to me. I have read, or have had explained, the information about the diseases and questions were answered satisfactorily. I understand the benefits and risk of the vaccine cited and ask that the vaccine be given to me or the person named above (for whom) I am authorized to make this request.

PATIENT or PARENT/LEGAL GUARDIAN SIGNATURE

Name: ______________________ Signature: ______________________ Date: ______________

Vaccine	Manufacturer	Lot#	Expiry	Route	Time Administered	VIS Date Publication	R.N. / LPN Signature Administration

Original-File • Pink-Data • Blue-Patient