PLEASE GIVE THE CLERK YOUR CHILD'S IMMUNIZATION RECORD WITH THIS FORM. (IT WILL BE RETURNED TO YOU)

www.HealthyOkaloosa.com

Client #:_____
Florida Department of Health-Okaloosa County
221 Hospital Dr. NE, Fort Walton Beach (FWB)
FWB Immunization Office Phone: (850) 833-9240
FWB Immunization Office Fax: (850) 833-3442
810 E James Lee Blvd, Crestview (CV)
CV Office Phone: (850) 689-7808

CHILD'S NAME: _____ DOB: _____ RACE: _____ M☐ F☐

ADDRESS: _____

CITY: _____ZIP CODE: _____PHONE: _____ GRADE: _____ AGE: _____

List the **names and date of birth for *all*** siblings in the home: _____

_____

_____

Form Completed by: _____ **Relationship to Child**: _____
(PRINT Parent or Guardian Name)

Date:

Does your child have Medicaid? ☐ **YES** ☐ **NO**
Does your child have health insurance? ☐ **YES** ☐ **NO**
Does the insurance pay for vaccines? ☐ **YES** ☐ **NO**
Is your child an American Indian or Alaskan Native? ☐ **YES** ☐ **NO**

Does your private physician usually administer your child's immunizations? ☐ **YES** ☐ **NO**

Will you bring your child to the Health Department for future immunizations? ☐ **YES** ☐ **NO**

Child's Country of Birth _____ Parents Country of Birth_____
(Date of Entry)

Please *tell the nurse* if any of the following apply to your child *today*.

* *For Females*: Is your child **pregnant or thinks she may be pregnant? If so, please notify the Nurse PRIOR to vaccinations**.

Weeks: ☐ **1-12** ☐ **13-27** ☐ **28-40**

* Your child has had the **CHICKEN POX DISEASE**:
* **Year of Disease:** _____
* Your child has a fever.
* Your child has an allergy to medication, food or any vaccine.
* Your child has had a serious reaction to a vaccine in the past.
* Your child has had seizures or any other brain problem.
* Your child has cancer, leukemia, HIV/AIDS or any other immune problem.
* Your child has taken cortisone, prednisone, steroids, anticancer drugs, or had x-ray treatments in the past 3 months.
* Your child has received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year.
* Your child has received any vaccinations within 4 weeks.

For Staff Use Only

VFC: PRIVATELY INSURED (Ins pays for vaccines)
VFC Eligible: Medicaid/MCO
VFC Eligible: UNDERINSURED
VFC Eligible: Uninsured
VFC Eligible: American Indian or Alaskan Native

For Staff Use Only

- Reason for visit _____
- Form 680 (blue card) ☐
  - **Parent/Guardian Waiting** ☐
  - **Will Pickup Later** ☐
- Record for Social Security Card ☐
- Immunizations ☐

Revised 2/8/19

INITIATION OF SERVICES

PART I **CLIENT-PROVIDER RELATIONSHIP CONSENT**

Client Name: _____

Name of Agency**: Florida Department of Health in Okaloosa County**

Agency Address: **221 Hospital Drive NE, Fort Walton Beach, Florida 32548**

I consent to entering into a client-provider relationship. I authorize Department of Health staff and their representatives to render routine health care. I understand routine health care is confidential and voluntary and may involve medical visits including obtaining medical history, assessment, examination, administration of medication, laboratory tests and/or minor procedures. I may discontinue this relationship at any time.

PART II **DISCLOSURE OF INFORMATION CONSENT** (treatment, payment or healthcare operations purposes only**)**

I consent to the use and disclosure of my health information; including medical, dental, HIV/AIDS, STD, TB, substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and health care operations.

PART III **MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST** (Only applies to Medicare Clients)

As Client/Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release my health information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the above-named agency and authorize it to submit a claim to Medicare for payment.

PART IV **ASSIGNMENT OF BENEFITS** (Only applies to Third Party Payers)

As Client /Representative signed below, I assign to the above-named agency all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personally responsible for charges not covered by this assignment.

PART V **COLLECTION, USE OR RELEASE OF SOCIAL SECURITY NUMBER**

(This notice is provided pursuant to Section 119.071(5)(a), Florida Statutes.)

For health care programs, the Florida Department of Health may collect your social security number for identification and billing purposes, as authorized by subsections 119.071(5)(a)2.a. and 119.071(5)(a)6., Florida Statutes. By signing below, I consent to the collection, use or disclosure of my social security number for identification and billing purposes only. It will not be used for any other purpose. I understand that the collection of social security numbers by the Florida Department of Health is imperative for the performance of duties and responsibilities as prescribed by law.

PART VI **MY SIGNATURE BELOW VERIFIES THE ABOVE INFORMATION AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS**

_____ _____ _____

Client/Representative Signature | Self or Representative's Relationship to Client | Date

_____ _____

Witness (optional) | Date

PART VII **WITHDRAWAL OF CONSENT**

I, _____ WITHDRAW THIS CONSENT, effective _____

Client/Representative Signature | Date

_____ _____

Witness (optional) | Date

Client Name: _____

ID#: _____

DOB: _____

Original to file; Copy to client

DH 3204-SSG-09-2019