Immunization Check-In Form

SHADED AREA MUST BE COMPLETED TO RECEIVE IMMUNIZATION

Patient Name _____ **Date of Birth** _____

Current Address *(Street, City, State, Zip)* _____ **Phone** _____

Card Holder's/Guarantor's Name _____ **Date of Birth** _____

Patient Gender: _____Male _____Female

Please choose the patient's type of medical insurance coverage and provide copy of the card

☐None ☐Medicaid ☐Private Insurance, ***Vaccine Covered*** ☐Private Insurance, ***Vaccine Not Covered***

CLINC LOCATION_____

FOR OFFICE USE ONLY

Immunizations Administered	Vaccine Name/Components
90715	Boostrix/Tdap
90700	Infanrix/Dtap
90714	TD (Tetanus & Diptheria)
90744	Enegerix- B/Hepatitis B (3 dose adolescent)
90746	Engerix-B Hepatitis B (3 dose adult)
90649	Gardasil/HPV
90651	Gardasil/HPV 9
90633	Havrix/Hepatits A (2 dose adolescent)
90632	Havrix/Hepatitis A (2 dose adult)
90696	Kinrix/Dtap - IPV
90707	MMR/Measles-Mumps-Rubella
90734	Meningococcal
90620	Meningococcal B (2 dose)
90723	Pediarix/Dtap - HepB - IPV
90647	ActHib/Hib
90698	Pentacel/Dtap – Hib - IPV
90732	Pneumovax 23/Pneumococcal Polynalent
90670	Prevnar 13/Pneumococcal 13
90713	IPOL/Inactivate Polio Vaccine
90680	Rotavirus
90716	Varivax/Varicella
90710	ProQuad/MMR & Varicella
90655	Influenza/.25ml Dose
90657	Influenza/Multi-Dose Vial 6 months & older
90656	Influenza/Single Dose Syringe 3yrs & older
90660	Influenza/ Intranasal (Flu Mist)

I hereby give consent for Public Health Solutions to administer the immunizations and bill my insurance.

X_____

Parent/Guardian Signature **Date**