Public Health Solutions
Immunization Check-in Form

Information must be completed to receive immunization(s)

Clinic Location: ______ Date ___/___/___ Time: ______
Adult Temperature: ________ Initial: ___________
Child/Teen Temperature: ________ Initial: ______
COVID-19 Date: ___/___/___ Initial: ___________
Insurance Card Copy: Initial: _____________
Form complete/signed: Initial: ___________

Complete

Patient Name: ______________________________ Date of Birth: _____/_____/____ Sex: □ Male □ Female
Telephone Number: ______________________________
Are you a Veteran? □ Yes □ No Do you have a family member that is a Veteran? □ Yes □ No
Would you like to be contacted by our VetSet Program Coordinator? □ Yes □ No
Address: ______________________ City ____________ State ___________ Zip Code ________
Insurance Cardholder's Name: ______________________ Date of Birth: _____/_____/_____

Type of medical insurance coverage.

□ None □ Medicaid □ Medicare □Private Insurance (Vaccine Covered) □Private Insurance (Vaccine Not Covered)

	Yes/Sí	No
Are you sick today? ¿Estás enfermo hoy?		
Do you have allergies to medications, gelatin, yeast, eggs or any vaccine? ¿Tienes alergías a medicamentos, gelatina, levadura, huevos o cualquier vacuna?		
Have you ever had a serious reaction to a vaccine in the past? ¿Alguna vez has tenido una reacción seria a una vacuna en el pasado?		
Have you had a seizure or a neurological problem? ¿Ha tenido una convulsión o un problema neurológico?		
Do you have cancer, leukemia, AIDS, or any other immune system problem? ¿Tiene cáncer, leucemia, SIDA o cualquier otro problema del sistema inmunológico?		
Do you take cortisone, prednisone, other steroids, anti-cancer drugs or X-ray treatments? ¿Toma cortisona, prednisona, ostros esteroides, medicamentos contra el cáncer o tratamientos de rayos X?		
Have you received a transfusion of blood, plasma, or a medicine called Immune Globulin in the past six months? ¿Ha recibido una transfusión de sangre, plasma o un medicamento llamado inmunoglobulina en los últimos seis meses?		
For Women: Are you pregnant or at risk for becoming pregnant? Para las mujeres: ¿Está embarazada o en riesgo de quedar embarazada?		
Have you had chickenpox? ¿Ha tendio varicela?		
Have you ever had Guillain-Barre' Syndrome? ¿Ha tenido alguna vez el síndrome de Guillain-Barré?		

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

X ______________________________________ ______/______/______
Patient/Parent/Guardian Date:

FOR OFFICE USE ONLY:

Name of parent/guardian to accompany child: ______________________________
Have you or your child been diagnosed with COVID-19? Yes/No Date: ___/___/___
Have you been around anyone the past 14 days who is positive for COVID-19? Yes/No
Have you or your child traveled outside the U.S. in the last 14 days? Yes/No
Do you or your child have any of the following: Fever or chills Yes/No Cough Yes/No Sore Throat Yes/No Loss of taste and/or smell Yes/No

Immunizations Administered/Components Vaccine Name

Adult

90651	HPV (Gardasil 9)
90632	Hepatitis A (2 dose adult) (Havrix)
90746	Hepatitis B (3 dose adult) (Engerix-B)
90660	Influenza/Intranasal (Flu Mist) - Quadrivalent
90657	Influenza/Multi-Dose 6 months & older - Quadrivalent
90686	Influenza/Single-Dose Syringe 6 months & older- Quadrivalent
90707	Measles-Mumps-Rubella (MMR II)
90734	Meningococcal A (Menveo)
90620	Meningococcal B (2 dose) (Bexero)
90732	Pneumococcal Polyvalent (Pneumovax 23)
90670	Pneumococcal 13 (Prevnar 13)
90714	Td – (Tetanus/Diphtheria Absorbed) (Tenivac)
90715	Tdap (Adacel) (Boostrix)
90716	Varicella (Varivax)

Child/Teen

90700	DTaP (Infanrix)
90696	DTaP-IPV (Kinrix)
90723	DTaP-HepB-IPV (Pediarix)
90698	DTap-IPV/Hib (Pentacel)
90633	Hepatitis A (2 dose ped/adolescent) (Havrix)
90744	Hepatitis B (3 dose ped/adolescent) (Engerix-B)
90647	HIB (ActHIB)
90651	HPV (Gardasil 9)
90660	Influenza/Intranasal (Flu Mist) – Quadrivalent
90686	Influenza/Single Dose Syringe 6 months & older - Quadrivalent
90657	Influenza/Multi-Dose Via 6 months & older – Quadrivalent
90707	Measles-Mumps-Rubella (MMR II)
90710	MMR & Varicella (ProQuad)
90734	Meningococcal A, C, Y, & W135 (Menveo)
90620	Meningococcal B (2 dose) (Bexero)
90670	Pneumococcal 13 (Prevnar 13)
90713	Polio Vaccine (IPOL Inactivated)
90680	Rotavirus
90714	Td- (Tetanus/Diphtheria Absorbed) (Tenivac)
90715	Tdap (Adacel) (Boostrix)
90716	Varicella/Varivax

Nurse Signature/Date

______________________________ ___/___/___