

**PLATTE COUNTY PUBLIC HEALTH**

718 9<sup>TH</sup> Street

Wheatland, Wyoming 82201 (307) 322-2540

www.plattecountypublichealth.com

Today's Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Parent/Guardian (if minor): \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Mailing Address

City

Who does patient usually see for regular health care? \_\_\_\_\_

Are you allergic to anything? Yes No If yes, what? \_\_\_\_\_

Are you allergic to latex? Yes No

Reason for today's visit: \_\_\_\_\_

**PAYMENT IS REQUIRED AT TIME OF SERVICE:**

**We accept cash, check or credit card.**

**You are responsible for billing your own insurance company.**

I agree to PCPH's payment policy. You may make a donation of \$10.00 for each immunization. I have received and read the Wyoming Department of Health Notice of Privacy Practices and have had a chance to ask questions about how my information will be used. (Please initial) \_\_\_\_\_

**Reason for today's visit:**

\_\_\_\_ Pregnancy test \$10.00

\_\_\_\_ TB test \$10.00

\_\_\_\_ Hemoglobin A1c \$30.00

\_\_\_\_ Rapid throat culture \$10.00

\_\_\_\_ Family Planning

\_\_\_\_ Health/Wellness

\_\_\_\_ Immunizations \$10.00/shot

\_\_\_\_ FNP visit

\_\_\_\_ Other

Donation

-----Office Use Only. DO NOT Write Below This Line-----

**Chief Complaint:**

**Nursing Assessment:**

**Procedures:**

**Referrals:**

**RN Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_ rev 07/09

Patient's Name: \_\_\_\_\_

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo. Day Year

### Screening Questionnaire for Child and Teen Immunizations

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If a question is unclear, please ask the nurse to explain it. Or if there is anything about your child's health you feel we should know that is not mentioned here, please talk to the nurse prior to your child receiving any vaccines.

	Yes	No	Unsure
1. Is the child sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the child have allergies to food, medicine or vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the child had a serious reaction to a vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the child had a seizure or brain problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Does the child have cancer, leukemia, AIDS or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Has the child taken cortisone, prednisone or other steroid or anticancer drug, or had x-ray treatments in the past 3 mos?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has the child received a transfusion of blood or blood products, or been given immune globulin in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Is the child/teen pregnant, or is there a chance she could become pregnant in the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Has the child received any vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Form completed by: \_\_\_\_\_ Date: \_\_\_\_\_

Form reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

**Did you bring your child's immunization record card with you today: yes no**

If yes, please give it to the nurse. If you don't have a personal record of your child's immunizations please ask, and we will provide one for you. It is important to take your child's immunization record with you to all medical appointments. Your child will need proof of immunizations to enter daycare or school.

I have received and read the Vaccine Information Statements for each shot my child will be getting and had my questions answered (initial here) \_\_\_\_\_ **OR**

I declined to receive the Vaccine Information Statements (initial here) \_\_\_\_\_