Chicago Department of Public Health IMMUNIZATION SERVICE FORM

1. DATE OF VISIT ____/____/____

2. Patient's Date of Birth

Month ☐☐ Date ☐☐ Year ☐☐☐☐

3. Age _____

4. Gender Listed on Driver's License/ Insurance

○ Female ○ Male ○ Other

5. Race

○ American Indian/Alaska Native
○ Asian
○ Black/African American
○ Native Hawaiian or other Pacific Islander
○ White
○ Other

6. Ethnicity

○ Hispanic or Latino
○ Not Hispanic or Latino

7. Patient's First Name **MI.** **8. Patient's Last Name**

9. Patient's Street Address & Apt # **10. Zip Code**

11. City **12. State** **13. Telephone Number**

14. Parent's/Guardian's First Name **MI.** **15. Parent's/Guardian's Last Name**

Office Use Only

Site
○ Englewood WIC
○ Greater Lawn WIC
○ Lower West WIC
○ Roseland WIC
○ Uptown WIC
○ CareVan 1
○ Westside CDC
○ Other

Office Use Only

Location
○ School
○ Childcare
○ Health Fair
○ WIC
○ Other

Insurance Information –To be completed by Recipient, Parent, or Guardian

16. Insurance Company Name (Medicaid, Medicare, Commercial or HMO)

17. Policy Number or Case ID number (If No Policy Number, Request SSN)

Office Use Only

VFC Eligible:
❍Medicaid (Title 19) ❍Uninsured (Self Pay) ❍Underinsured ❍AI/AN

Non VFC Eligible:
❍CHIP (Title 21/State-Funded) ❍Commercial

Non VFC Eligible: Adults
❍Uninsured ❍Insured

Assessment for Immunizations - To be completed by Recipient, Parent or Guardian

IMPORTANT: If an answer is Yes (Y) or Unknown (U) please consult a physician

	Y	N	U
18. Is the patient sick or have a high fever? If yes, list symptoms: _____	❍	❍	❍
19. Has patient taken cortisone, prednisone, other steroids, anticancer drugs or x-rays in the past 3 months?	❍	❍	❍
20. Does the patient have cancer, leukemia, HIV/AIDS or other immune system problems?	❍	❍	❍
21. Has the patient had a serious reaction to vaccine in the past?	❍	❍	❍
22. Has the patient had a seizure or brain disorder?	❍	❍	❍
23. Does the patient have any allergies to medications, food, or any vaccine? If yes, list symptoms: _____	❍	❍	❍
24. Has the patient received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year?	❍	❍	❍
25. Is the person being vaccinated pregnant?	❍	❍	❍
26. Has the patient received any vaccinations in the past 4 weeks?	❍	❍	❍
27. Has the patient had chickenpox disease in the past?	❍	❍	❍

I certify that to the best of my knowledge and belief, the information I have provided is true, correct and complete. I understand I have the right to appeal any assessed fees and to have a fair hearing regarding said fee. I authorized the Chicago Department of Public Health (CDPH) staff to collect and use all personal and demographic data supplied by me for statistical purposes. I authorized the CDPH staff to release to the Social Security Administration, its intermediaries, any public or private insurance, and any information needed related to claim for payment. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to CDPH. I authorized the CDPH staff to examine me and administer any treatment medical and/or surgical as may be advisable in the diagnoses and treatment.

I have received a copy and have read or had explained to me the information from the vaccine information statement(s) about the vaccine(s) that will be given today. I have had a chance to ask questions and they were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) that will be given today and ask that the vaccine(s) be given to me or the person named on this form for whom I am authorized to make this request. My signature indicates that I fully understand the above information.

X _____ _____
1. Signature of Recipient, Parent or Guardian — Date

I have been presented with the City of Chicago's Notice of Privacy Practices.

X _____ _____
2. Signature of Recipient, Parent or Guardian — Date

Office Use Only

√	Service	DX	CPT	Fee
	DTaP	Z23	90700	$50
	DTaP/HepB/IPV	Z23	90723	$120
	DTaP/IPV/HIB	Z23	90698	$120
	DTaP/IPV	Z23	90696	$80
	IPV	Z23	90713	$50
	HIB - ActHIB	Z23	90648	$45
	HIB - Pedvax	Z23	90647	$35
	HIB/Hep B - Comvax	Z23	90748	$65
	Hep A (Peds)	Z23	90633	$45
	Hep B (Peds)	Z23	90744	$35
	PCV 13	Z23	90670	$165
	Rotavirus	Z23	90680	$100
	MMR	Z23	90707	$80
	Varicella	Z23	90716	$135
	MMRV	Z23	90710	$215
	Tdap	Z23	90715	$50
	HPV	Z23	90649	$180
	MCV4	Z23	90734	$150
	Meningococcal B	Z23	90620	$200
	Tenivac	Z23	90714	$35
	Hep A (Adult)	Z23	90632	$85
	Hep B (Adult)	Z23	90746	$85
	Hep A/B (Adult)	Z23	90636	$125
	MPSV4	Z23	90733	$160
	PPSV23	Z23	90732	$100
	Td (Adult)	Z23	90718	$28
	Zoster	Z23	90736	$220
	Influenza < 3 years	Z23	90685	$30
	Influenza > 3 years	Z23	90686	$30
	Influenza Flumist	Z23	90672	$30
	Influenza Flulaval (Mdcr)	Z23	Q2036	$30
	Influenza Fluzone (Mdcr)	Z23	Q2038	$30
	Influenza High Dose (Mdcr)	Z23	90662	$35

	Administration	DX	CPT	Fee
	Admin - single vaccine	Z23	90471	$25
	Admin - subsequent vaccine	Z23	90472	$15
	Intranasal admin	Z23	90473	$20
	Intranasal admin - subsequent	Z23	90474	$15
	Admin - Medicare Influenza	Z23	G0008	$25
	Admin - Medicare Pneumoco	Z23	G0009	$25
	Admin - Medicare Hep B	Z23	G0010	$25
	VFC Admin	Z00129	99211	$12.30

Total Charge = _____

❍ Invoice ❍ Insurance Claim ❍ Hardship

Nurse: _____

VACCINE ADMINISTRATION RECORD & HISTORY

If a combination vaccine (e.g., HepB + Hib, DTaP-HepB-IPV, etc.) is used, record the dose in each section.
NOTE: If you are recording a vaccine given elsewhere, record date dose was given; write in "elsewhere" or "transcribed," and/or name of provider.

VACCINE	DATE GIVEN *	MANUFACTURER and LOT NUMBER	EXPIRATION DATE	ROUTE / SITE **	DATE ON VIS †	VACCINE	DATE GIVEN*	MANUFACTURER and LOT NUMBER	EXPIRATION DATE	ROUTE / SITE**	DATE ON VIS †
Diphtheria, Tetanus, Pertussis (e.g., DTaP-HepB-IPV DTaP-IPV-HIB DTaP-IPV Td, Tdap, Dt)				IM		**Haemophilus Influenzae type b** (e.g., Hib, DTaP-IPV-HIB)				IM	
				IM						IM	
				IM						IM	
				IM						IM	
				IM		**Hepatitis B** (Hep B, DTaP-HepB-IPV)				IM	
				IM						IM	
				IM						IM	
Polio (IPV DTaP-HepB-IPV DTaP,IPV-Hib DTaP-IPV)				IM						IM	
				IM		**Varicella**				SC	
				IM						SC	
				IM		☐ Check here if patient had chickenpox and does not need vaccine.					
Measles, Mumps, Rubella (e.g.,MMR, MMRV)				SC		**Pneumococcal Conjugate (PCV)**				IM	
				SC						IM	
Hepatitis A (Hep A)				IM						IM	
				IM						IM	
Rotavirus				Oral						IM	
				Oral		**Meningococcal (MCV)**				IM	
				Oral						IM	
Influenza TIV = IM TIV=ID LAIV = IN						**Human Papillomavirus (HPV)**				IM	
										IM	
Men B				IM						IM	
				IM		**Other**					

*__Date Given__ is both the date the vaccine was administered and the date the Vaccine Information Statement (VIS) was given to the patient/parent/guardian.
**__Injection Site__: LD=Left Deltoid; LT=Left Thigh; RD=Right Deltoid; RT=Right Thigh. Proper route indicated by italics: IM = intramuscular, SC = subcutaneous, IN= intra-nasal, ID=Interdermal
†Record the publication date of each VIS. According to federal law, VISs must be given to patients (or parent/guardian of a minor) before administering each dose of vaccine.
MANUFACTURERS: GSK= GlaxoSmithKlin**e; ME =** Merck**, SP =** SanofiPasteur**, P =** Pfizer**, MI =** MedImmune**, Nov =** Novartis

Vaccinator Signature:_____ **Title:**_____ **Date:**_____