Immunization Documentation

SECTION I: To be completed by Client or Parent/Legal Guardian (if client less than 16 years of age).

DEMOGRAPHICS

Name:			**Date of Birth:**	**Age:**
Address:				**County:**
Telephone:	☐ cell ☐ home	**Race:**	**Sex:**	**MCI Number** (Staff Use Only)
Preferred Method of Contact: ☐ Call ☐ Mail	**Preferred Phone/Address (if different from above)**			
Emergency Contact:			**Emergency Phone:**	

By my signature below as client, parent, legal guardian, or other responsible party, I hereby give my consent to and authorize South Carolina Department of Health and Environmental Control employees and agents to provide immunization services and medical care to me or, in case of a parent or legal guardian, to my child or ward.

Client/Parent/Legal Guardian Signature **Date** **Relationship to Client:**

SECTION II: To be completed by DHEC staff.

VACCINE HISTORY

Previous dose(s) of vaccine as applicable (include dates):	**Pregnancy Status:** ☐ pregnant ☐ not pregnant ☐ N/A (male)
Allergies/Comments:	☐ **No Contraindications**

ELIGIBILITY

ADULT ELIGIBILITY (Persons ≥19 yrs. of Age)		CHILD ELIGIBILITY (Persons ≤18 yrs. of Age)	
1. Adult > No Health Insurance	6. Fee-For Service > No Health Insurance	10. Pediatric VFC > Medicaid	13. Pediatric State > Underinsured
2. Adult > Underinsured	7. Fee-For-Service > Underinsured	11. Pediatric VFC > American Indian/Alaska Native	14. Pediatric State > Insured
3. Fee-For-Service > Insured	8. Disease Control	12. Pediatric VFC > No Health Insurance	15. Preparedness Exercise
4. Fee-For-Service > Medicaid	9. Preparedness Exercise		
5. Fee-For-Service > Medicare			

DOCUMENTATION

Vaccine Name	Dosage	Dose #*	Site	Route	Manufacturer	Lot #	VIS Date	Elig.
INACTIVATED INFLUENZA ☐ IIV4 ☐ ccIIV4 ☐ IIV4-High Dose	☐ 0.5 mL	☐ 1 ☐ 2	☐ LA ☐ RA ☐ LL ☐ RL	IM			8/15/19	
LIVE ATTENUATED INFLUENZA (LAIV4)	☐ 0.2 mL	☐ 1 ☐ 2	R and L Nare	Intra-nasal			8/15/19	
PNEUMOCOCCAL CONJUGATE (PCV13)	☐ 0.5 mL		☐ LA ☐ RA ☐ LL ☐ RL	IM			10/30/19	
PNEUMOCOCCAL POLYSACCHARIDE (PPSV23)	☐ 0.5 mL		☐ LA ☐ RA ☐ LL ☐ RL	☐ IM ☐ SC			10/30/19	
TETANUS (Td)	☐ 0.5 mL		☐ LA ☐ RA ☐ LL ☐ RL	IM			4/01/20	
TETANUS (Tdap)	☐ 0.5 mL		☐ LA ☐ RA ☐ LL ☐ RL	IM			4/01/20	
VARICELLA	☐ 0.5 mL	☐ 1 ☐ 2	☐ LA ☐ RA ☐ LL ☐ RL	SC			8/15/19	
HEPATITIS A	☐ 0.5 mL ☐ 1.0 mL	☐ 1 ☐ 2	☐ LA ☐ RA ☐ LL ☐ RL	IM			07/28/20	
HEPATITIS B	☐ 0.5 mL ☐ 1.0 mL	☐ 1 ☐ 2 ☐ 3	☐ LA ☐ RA ☐ LL ☐ RL	IM			8/15/19	
MMR	☐ 0.5 mL	☐ 1 ☐ 2	☐ LA ☐ RA ☐ LL ☐ RL	SC			8/15/19	
MENINGOCOCCAL ☐ MenACWY-D (Menactra) ☐ MenACWY-CRM (Menveo)	☐ 0.5 mL	☐ 1 ☐ 2 ☐ 3 ☐ 4	☐ LA ☐ RA ☐ LL ☐ RL	☐ IM ☐ SC			8/15/19	
MENINGOCOCCAL B ☐ Trumenba ☐ Bexsero	☐ 0.5 mL	☐ 1 ☐ 2 ☐ 3	☐ LA ☐ RA ☐ LL ☐ RL	IM			8/15/19	
Zoster Recombinant (RZV)	☐ 0.5 mL	☐ 1 ☐ 2	☐ LA ☐ RA	IM			10/30/19	
IG Type:_____ Wgt:_____								

Signature/Title of Person Administering Vaccine:	**Date:**
Clinic Site or Health Department:	IIS Entry Complete: ☐

*Dose # is product dependent.

BILLING

Name:	Date of Birth:

☐ Medicare Card Number_____
(include alpha suffix – all letters and numbers)

☐ Medicaid Card Number _____

☐ Other Insurance Company_____Policy Number_____

Name and Social Security Number of Policy Holder *(if different from demographic section)*_____

Billing Certification & Privacy Notice

By my signature below as parent, guardian or client, I request that payment of Medicare/Medicaid or other Third Party Insurance benefits be made on behalf of the South Carolina Department of Health and Environmental Control for any services provided me. Permission is also granted to DHEC to exchange medical or other confidential information as necessary to the Centers for Medicaid Services (CMS), its agents or other agents needed to determine these benefits for related services

If applicable, I also agree to participate in treatment plans, assignment of insurance, Medicaid or Medicare benefits to DHEC for services rendered and to participate in payment for services as determined by specific program guidelines.

I acknowledge that I have been provided with a copy of DHEC's Privacy Notice. Patient refused notice? ☐ Yes

Signature (Client/Legal Guardian)	Date	Witness (if client signs with "X")	Date