QFlow #:

Date:

FLORIDA DEPARTMENT OF HEALTH IN ORANGE COUNTY
IMMUNIZATION SCREENING AND CONSENT FORM

Your child may need one or more vaccines required for school attendance. **For your child to receive vaccines you must complete this form.** Florida Department of Health in Orange County licensed staff will provide free of charge immunizations to eligible children through Vaccines for Children program.

SECTION 1: INFORMATION ABOUT CHILD -PLEASE PRINT

Last Name	First Name	Middle Name

Child's Date of Birth		Age	Child's Gender
Month	Day	Year	☐ Male ☐ Female

Child's Race (Select all that apply)

☐ American Indian or Alaska Native ☐ Black or African American
☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ White

Child's Preferred Language (Interpreter needed? ☐ Yes ☐ No)	Child's Ethnicity Hispanic/Latino: ☐ Yes ☐ No

Child's Address

City	State	Zip Code	Country of Birth

Is the child currently enrolled in an Orange County School? ☐ Yes ☐ No	What grade will the child be in school this year? 2020-2021

Was the child born in Florida? ☐ Yes ☐ No

Parent/Legal Guardian's Information

Last	First	Middle Name

Relationship to child	Preferred Language Interpreter needed? ☐ Yes ☐ No	
Phone Number	Date of Birth	
	Month	Day / Year

HMS MRN	FLShots ID # (State Imm ID)	Insurance	680 Only	No Services	Registration Clerk

SECTION 2: SCREENING FOR VACCINE ELIGIBILITY

The following questions will help us determine which vaccines the child may be given. If you answer "yes" to any question, it does not necessarily mean the child should not be vaccinated.

Please check YES or No for each question	YES	NO
1. Is the child sick today? Had a fever in the last 24 hours (greater than 100.4°)?		
2. Does the child have allergies to **medications, food, a vaccine component, environment or latex**? Please explain		

Allergen(s)		Date of onset
Reaction(s)		Severity ☐ Mild ☐ Moderate ☐ Severe

3. Has the child ever had chicken pox disease? If yes, at what age _____ OR in what year _____		
4. Has the child had a **serious reaction** to a vaccine in the past?		
5. Has the child had a health problem with **lung, heart, kidney or metabolic disease** (e.g. diabetes), **asthma** or a **blood disorder**?		
6. Has the **child,** a **sibling**, or a **parent** had a **seizure**; has the child had **brain** or other **nervous system** problems?		
7. Does the **child** have **cancer, leukemia, HIV/AIDS** or any other **immune system** problems?		
8. In the past **three months** has the child taken **medications** that affect the immune system such as **prednisone, other steroids**, or **anticancer drugs**; drugs for the treatment of **rheumatoid arthritis, Crohn's disease**, or **psoriasis;** or had **radiation treatment**?		
9. In the past year, has the child received a **transfusion** of **blood** or **blood products** or been given **immune (gamma) globulin** or an **antiviral drug**?		
10. Is the child/teen **pregnant** or is there a **chance** she could become pregnant during the next month? **LMP?** _____		
11. Has your child **been vaccinated or tested for Tuberculous (TB) within the last 30 days**? If YES Vaccine type and date: _____ or TB test read date: _____		

Nurse Name Printed		Nurse Signature		Date:	

Florida HEALTH
Orange County

INITIATION OF SERVICES

QFlow #:

PART I **CLIENT-PROVIDER RELATIONSHIP CONSENT**

Client Name: _____

Name of Agency: **Florida Department of Health - Orange**

Agency Address: **6101 Lake Ellenor Drive, Orlando, Florida 32809**

I consent to entering into a client-provider relationship. I authorize Department of Health staff and their representatives to render routine health care. I understand routine health care is confidential and voluntary and may involve medical visits including obtaining medical history, assessment, examination, administration of medication, laboratory tests and/or minor procedures. I may discontinue this relationship at any time.

PART II **DISCLOSURE OF INFORMATION CONSENT**

(treatment, payment or healthcare operations purposes only)

I consent to the use and disclosure of my health information; including medical, dental, HIV/AIDS, STD, TB, substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and health care operations.

PART III **MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST**

(Only applies to Medicare Clients)

As Client/Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release my health information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the above-named agency and authorize it to submit a claim to Medicare for payment.

PART IV **ASSIGNMENT OF BENEFITS**

(Only applies to Third Party Payers)

As Client /Representative signed below, I assign to the above-named agency all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personally responsible for charges not covered by this assignment.

PART V **COLLECTION, USE OR RELEASE OF SOCIAL SECURITY NUMBER**

(This notice is provided pursuant to Section 119.071(5)(a), Florida Statutes.)

For health care programs, the Florida Department of Health may collect your social security number for identification and billing purposes, as authorized by subsections 119.071(5)(a)2.a. and 119.071(5)(a)6., Florida Statutes. By signing below, I consent to the collection, use or disclosure of my social security number for identification and billing purposes only. It will not be used for any other purpose. I understand that the collection of social security numbers by the Florida Department of Health is imperative for the performance of duties and responsibilities as prescribed by law.

PART VI **MY SIGNATURE BELOW VERIFIES THE ABOVE INFORMATION AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS**

_____ _____ _____

Client/Representative Signature | Self or Representative's Relationship to Client | Date

_____ _____

Witness (optional) | Date

PART VII **WITHDRAWAL OF CONSENT**

I,_____WITHDRAW THIS CONSENT, effective _____

Client/Representative Signature | Date

_____ _____

Witness (optional) | Date

Original to file; Copy to client

DH 3204-SSG-09-2019

For Office Use Only – Print or Use Label

Client Name: _____

MRN: _____

DOB: _____