CHILD IMMUNIZATION SERVICE FORM
Chicago Department of Public Health

DATE OF SERVICE MM DD YYYY

Patient's First Name | **MI.** | **Patient's Last Name**

Patient's Social Security (optional) | **Patient's Date of Birth** MM DD YYYY | **Sex** ○ M ○ F

Patient's Street Address | **Zip Code**

Telephone Number | **Second Alternate Telephone Number**

Parent's / Guardian First Name | **MI.** | **Parent's / Guardian Last Name**

Location
- ○ Childcare
- ○ FastTrack
- ○ Health Fair
- ○ Public Housing
- ○ School
- ○ Other

Site
- ○ Austin - CC
- ○ Care Van 1
- ○ Care Van 2
- ○ Englewood
- ○ Englewood – CC
- ○ Greater Lawn
- ○ LowerWest WIC
- ○ Roseland-WIC
- ○ Trina Davila
- ○ Uptown
- ○ Westside CDC
- ○ Other

Insurance Information
○ Medicaid ○ Medicare ○ Other Insurance ○ Self Pay

Medicaid Status
○ MPE Pending ○ Kidcare ○ HMO

Subscriber's First Name (if not Patient) | **MI.** | **Case or Subscriber Last Name or "Self"**

Medicaid Recipient Number | **Medicare Number**

Medicaid Case Number | **Other Insurance Company (Commercial or HMO)**

Policy Number | **Group Number**

Race
- ○ Asian or Pacific Islander
- ○ Black
- ○ White
- ○ Other
- ○ Unknown

Hispanic
- ○ Yes
- ○ No

Ethnicity
- ○ Cambodian
- ○ Chinese
- ○ Cuban
- ○ Guatemalan
- ○ Haitian
- ○ Korean
- ○ Mexican
- ○ Other Latin
- ○ Other Non White
- ○ Other White
- ○ Polish
- ○ Puerto Rican
- ○ Salvadorean
- ○ Vietnamese
- ○ Unknown

ASSESSMENT FOR IMMUNIZATIONS

IMPORTANT: If an answer is Y or U please consult a physician

	Y	N	U
1. *Is the patient sick or have a high fever? If yes list symptoms at the bottom of this form.	○	○	○
2. Has the patient taken cortisone, prednisone, other steroids, anticancer drugs or x-rays in the past 3 months?	○	○	○
3. Does the patient have cancer, leukemia, HIV/AIDS or other immune system problems?	○	○	○
4. Has the patient had a serious reaction to vaccine in the past?	○	○	○
5. Has the patient had a seizure or a brain problem?	○	○	○
6. Does the patient have any allergies to medications, food, or any vaccine?	○	○	○
7. Has the patient received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year?	○	○	○
8. Is the person being vaccinated pregnant?	○	○	○
9. Has the patient received any vaccinations in the past 4 weeks?	○	○	○
10. Has the patient had chickenpox disease in the past?	○	○	○

*** If yes, please list symptoms:**

Y=Yes N=No U=Unknown

Referral Source
- ○ MD
- ○ Reminder/Recall
- ○ WIC
- ○ Other

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, 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 diagnose and treatment.

X _____ _____

Signature of Recipient, Parent or Guardian | Date

Provider ID Code

F07R1P1 022007

Vaccine Administration

Manufacturer's Code – NV:Novartis – GK:GSK – MK:Merck – MI:MedImmune – SA:Sanofi – WY:Wyeth

VACCINATION ADMINISTRATION (INDICATE # AS APPROPRIATE)							MANUFACTURER						DATE ON VIS	ROUTE		SITE			
DOSE	1	2	3	4	5	LOT NUMBER	NV	GK	MK	MI	SA	WY	(mmddyy)	IM	SC	LD	LT	RD	RT
90700 DTaP																			
90723 DTaP/HepB/IPV																			
90714 Td																			
90715 Tdap																			
90702 DT																			
90713 IPV																			
90648 HIB-ActHIB																			
90647 HIB-Pedvax																			
90748 HIB/Hep B																			
90707 MMR																			
90710 MMR/Varicella																			
90744 Hep B (Peds)																			
90716 Varicella																			
90633 Hep A (Peds)																			
90669 PCV 7																			
90732 PPV23																			
90680 Rotavirus																			
90734 MCV4																			
90733 MPSV4																			
90655 Influenza <3yrs, T-free																			
90656 Influenza >3yrs, T-free																			
90657 Influenza <3yrs																			
90658 Influenza >3yrs																			
90660 Influenza-Flumist																			
90649 HPV																			

Route: IM=Intramuscularly, SC=Subcutaneous - Injection Site: LD=Left Deltoid; LT=Left Thigh; RD=Right Deltoid; RT=Right Thigh

Historical Data

If a combination vaccine (e.g., HepB, Hib, DTaP-HepB-IPV, etc.) is used, record the dose in each section.

VACCINE	Date Given (mmddyy)
Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-HepB-IPV, Td, TdaP)	
Measles, Mumps, Rubella (MMR)	

VACCINE	Date Given (mmddyy)
Haemophilus influenza type b (e.g., Hib, Hib-HepB)	
Hepatitis B (Hep B)	
Meningococcal MCV4	

VACCINE	Date Given (mmddyy)
HPV	
Pneumococcal Conjugate (PCV7)	
Hepatitis A (Hep A)	

VACCINE	Date Given (mmddyy)
Polio (e.g., IPV, DTaP-HepB-IPV)	
Varicella	
☐ Check if patient had chickenpox and does not need vaccine	
Rotavirus	

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 _____ _____ _____

Signature of Recipient, Parent or Guardian | Date | Signature and Title of Person Administering | Date

F07R1P2 022007

Mental Health Records Pursuant to the Illinois Mental Health and Disabilities Act, 740 ILCS 110 et seq., we may release protected health information contained in mental health records without your authorization when the disclosure is made to: *(a)* a supervisor, consulting therapist or records custodian; *(b)* a peer review committee; *(c)* our attorney(s); *(d)* the appropriate authorities when required to report abuse, neglect, suicide or homicide; and *(e)* in response to a court ordered subpoena.

Other Uses and Disclosures Other uses and disclosures of your PHI will only be made upon receiving your written authorization, unless otherwise permitted or required by law as described below. You may revoke an authorization at any time by providing written notice to us that you wish to revoke an authorization. We will honor a request to revoke to the extent that we have not already used or disclosed your PHI in good faith with the authorization.

Individuals Involved in Your Health Care
Unless you object, we may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. We may also give information to someone who helps pay for your care. Additionally, we may use or disclose PHI to notify or assist in notifying a family member. Finally, we may use or disclose your PHI to an authorized public entity to assist in disaster relief efforts and coordinate uses and disclosures to family or other individuals involved in your care.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right to Request Restrictions on Uses and Disclosures You have the right to request that the health care component limit its uses and disclosures of PHI in relation to treatment, payment and health care operations or not use or disclose your PHI for these reasons at all. You also have the right to request that we restrict the use or disclosure of your PHI to family members or personal representatives. Any such request must be made in writing to the Privacy Officer listed in this Notice and must state the specific restriction requested and to whom that restriction would apply.

The health care component is not required to agree to a restriction that you request. However, if it does agree to the requested restriction, it may not violate that restriction except as necessary to allow the provision of emergency medical care to you.

Right to Receive Confidential Communication You have the right to request that communications involving PHI be provided to you at an alternative location or by an alternative means of communication. The health care component is required to accommodate any reasonable request if the normal method of disclosure would endanger you and that danger is stated in your request. Any such request must be made in writing to the Privacy Officer listed in this Notice.

Right to Access Your PHI You have the right to inspect and copy your PHI that is contained in a designated record set for as long as the City maintains the PHI. A designated record set contains medical and billing records and any other records that the health care component uses for making decisions about you. Under federal law, however, you may not inspect and copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to laws that prohibit access to PHI.

Right to Amend PHI You have the right to request that PHI in a designated record set be amended for as long as the City of Chicago maintains the information. The City may deny your request for amendment if we determine that the PHI was not created by the City, is not part of the designated record set, is not information that is available for inspection, or that the PHI is accurate and complete. If your request for amendment is declined, you have the right to have a statement of disagreement included with the PHI and the City has a right to include a rebuttal to your statement, a copy of which will be provided to you. Requests for amendment of your PHI should be directed to the Privacy Officer listed in this Notice.

Right to Receive an Accounting of Disclosures You have the right to receive an accounting of all disclosures of your PHI that the City has made, if any, for reasons other than disclosures for treatment, payment and health care operations, as described above, and disclosures made to you or your personal representative. Your right to an accounting of disclosures applies only to PHI created by the City after April 14, 2003 and cannot exceed a period of six years prior to the date of your request. Requests for an accounting of disclosures of your PHI should be directed to the Privacy Officer listed in this Notice.

Right to Receive a Paper Copy of this Notice You have the right to receive a paper copy of this Notice upon request. Requests for a paper copy of this Notice should be directed to the Privacy Officer listed in this Notice.

Privacy Complaints If you believe your privacy rights have been violated, you may file a complaint with the City of Chicago or the U.S. Secretary of Health and Human Services. Complaints should be filed in writing with the Privacy Officer listed in this Notice. The City will not retaliate against you for filing a complaint.

You may contact the City of Chicago's Privacy Officer at (312) 747-2237 for further information about the complaint process.

This notice was published and becomes effective on April 14, 2003.

Date: April, 2003
Form # 28-3110-0704
4/03

Richard M. Daley, Mayor
City of Chicago

CITY OF CHICAGO'S NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice please contact: The City of Chicago's Privacy Officer at (312) 747-2237

This Notice of Privacy Practices describes how the City of Chicago may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

The City is required to abide by the terms of this Notice of Privacy Practices. The City may change the terms of our notice, at any time. The new notice will be effective for all PHI that the City maintains at that time. You may obtain a copy of the Notice of Privacy Practices by accessing the City of Chicago's web site, ***www.cityofchicago.org***, by calling the City of Chicago's Privacy Officer to request that a copy be mailed to you, or by asking for a copy at your next appointment.

ACKNOWLEDGMENT OF RECEIPT OF THIS NOTICE

You will be asked to provide a signed acknowledgment of receipt of this notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of health care services will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

WHO WILL FOLLOW THIS NOTICE

This notice describes the City of Chicago health care component's practices regarding your protected health information. For this notice, the City of Chicago health care component includes the following:

- The Chicago Department of Public Health
- The Chicago Fire Department
- The Chicago Department on Aging (case management division)

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Treatment, Payment and Health Care Operations Federal law allows a health care provider to use and disclose PHI for the purposes of treatment, payment and health care operations without your consent or authorization. Examples of the uses and disclosures that the City, as a health care provider, may make under each section are listed below:

• **Treatment** Treatment refers to the provision and coordination of health care by a doctor, hospital or other health care provider. As a health care provider, we will use and disclose PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your PHI. For example, we would disclose your PHI, as necessary, to another physician, or health care provider (for example, a specialist, pharmacist, or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment. In emergencies, we will use and disclose your PHI to provide the treatment you require.

• **Payment** Payment refers to the activities of the City of Chicago to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

• **Health Care Operations** Health care operations refers to the basic business functions necessary to operate as a health care provider. The City of Chicago may use or disclose, as needed, your protected health care information in order to support the business activities of the health care component. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. We may also use or disclose your PHI to other City of Chicago departments for the health care operations of the health care component.

For example, we use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may also use or disclose your PHI, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that might interest you. For example, your name and address may be used to send you a newsletter about the health care services we offer. We may also send you information about products or services that we believe might benefit you.

We will share your PHI with third party business associates that perform various activities (e.g., billing, legal services) for the City, but only to the extent necessary to complete the activities. Whenever an arrangement between the City and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.

Other Uses and Disclosures Allowed Without Authorization Federal law also allows the City of Chicago to use and disclose PHI, without your consent or authorization, in the following ways:

1. ***Public Health Risks*** The City of Chicago health care component may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:
   - maintaining vital records, such as births and deaths
   - reporting child abuse or neglect
   - preventing or controlling disease, injury or disability
   - notifying a person regarding potential exposure to a communicable disease
   - notifying a person regarding a potential risk for spreading or contracting a disease or condition
   - reporting reactions to drugs or problems with products or devices
   - notifying individuals if a product or device they may be using has been recalled
   - notifying appropriate government agencies and authorities regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
   - notifying your employer under limited circumstances related primarily to workplace injury or illness.

   As a public health authority, we may also use your PHI for the above stated public health purposes.

2. ***Health Oversight Activities*** We may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. ***Lawsuits and Similar Proceedings.*** We may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or other similar proceeding. We may also disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. ***Law Enforcement*** We may release PHI if asked to do so by a law enforcement official:
   - regarding a crime victim in certain situations, if we are unable to obtain the person's agreement;
   - concerning a death we believe has resulted from criminal conduct;
   - regarding criminal conduct at our offices;
   - in response to a warrant, summons, court order, subpoena or similar legal process;
   - to identify/locate a suspect, material witness, fugitive or closures that may be made.
   - in an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

5. ***Deceased Patients*** The City of Chicago may release PHI to a medical examiner to identify a deceased individual or to identify the cause of death. If necessary, we may also release information in order for funeral directors to perform their jobs. PHI may be used and disclosed for cadaveric organ, eye, or tissue donations.

6. ***Research*** The City of Chicago may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board; (b) the health care component obtains the oral or written agreement of a researcher that (i) the information being sought is solely to review PHI as necessary to prepare a research protocol or for similar purposes preparatory to research; (ii) the use or disclosure of your PHI is being used only for the research; and (iii) the researcher will not remove any of your PHI from our clinics; or (c) the PHI sought by the researcher only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access to the PHI of the decedents.

7. ***Serious Threats to Health or Safety*** Consistent with applicable federal and state laws, the City of Chicago may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

8. ***Military*** The City of Chicago may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

9. ***National Security*** The City of Chicago may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We may also disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations, as authorized by law.

10. ***Inmates*** The City of Chicago may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. This disclosure would be necessary (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

11. ***Workers Compensation.*** The City of Chicago may release your PHI as authorized by and to the extent necessary to comply with laws relating to workers compensation and similar programs.

The examples of permitted uses and disclosures listed above are not provided as an all inclusive list of the ways in which PHI may be used. They are provided to describe in general the types of uses and disclosures that may be made.