

Eastern Idaho Public Health - Childhood Immunization Consent Form

Clinic Name: EIRMC CLINIC

Clinic Date: 04/11/2026

Demographic information about person receiving vaccine (Please print)

First Name:		Last Name:	
Date of Birth:		Age:	Gender: Male Female
Last 4 of SSN (Only ≥18yrs old): XXX-XX-_____		Phone Number:	
Mailing Address:		<input type="checkbox"/> Check box if address is the same as other family members, provide name of client to reference for address information: _____	
City:	State:	Zip:	
Race: <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other		Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	

Only for 0-18 years of age: Vaccine Eligibility Screening (Please check appropriate box)

- American Indian/Alaskan Native:** A child, 0 thru 18 years of age, who identifies as an American Indian or Alaskan Native, regardless of insurance coverage.
- No Health Insurance:** A child, 0 thru 18 years of age, who does not have health insurance.
- Limited Health Insurance:** A child, 0 thru 18 years of age, who has health insurance, but the health insurance does not pay for vaccinations.
- Medicaid:** A child, 0 thru 18 years of age, who are enrolled in a Medicaid program or are eligible for Medicaid

INSURANCE INFORMATION: Please provide the following information

PRIMARY INSURANCE:

Insurance Company Name: _____	Policy Holder Name: _____	Policy Holder DOB: _____
<input type="checkbox"/> Check box if insurance is the same as other family members, provide name of client to reference for insurance: _____		

SECONDARY INSURANCE:

Insurance Company Name: _____	Policy Holder Name: _____	Policy Holder DOB: _____
Policy Holder DOB: _____		
<input type="checkbox"/> Check box if insurance is the same as other family members, provide name of client to reference for insurance: _____		

There are certain vaccines recommended for various age groups, vaccines are recommended but never required.

The following question will help us determine which vaccine may be given today. If you answer “yes” to any question, it does not necessarily mean you should not be vaccination. It just means we need to ask you more questions. If a question is not clear, please ask your healthcare provider to explain it.

Questions	Yes	No	Comments
1. Is your child sick today?			
2. Does your child have allergies to medications, food a vaccine component or latex?			
3. Has your child ever had a serious reaction after receiving a vaccine?			
4. Does your child have any of the following: long term health problems with heart, lung, kidney, or metabolic disease(e.g., Diabetes), asthma, blood disorder, no spleen, a cochlear implant, or a spinal fluid leak?			
5. Is your child on a long-term aspirin?			
6. Does your child have cancer, leukemia, HIV/AIDS, or any other immune system problem?			
7. Does your child have a parent, brother or sister with an immune system problem?			
8. In the past 6 months, has your child taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Chron’s disease, or psoriasis; or have you had radiation treatment?			
9. Has your child had a seizure or a brain or other nervous system problem?			
10. Has your child ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an injection with the virus that causes COVID-19?			
11. In the past year, has your child received immune (gamma) globulin, blood/blood products or antiviral drug?			
12. Females only: Is your child pregnant?			
13. Has your child received any vaccination in the past 4 weeks?			
14. Has your child ever felt dizzy or fainted before, during, or after a shot?			
15. Is your child anxious about getting a shot today?			
16. Other than listed in the above questions, does your child have an underlying condition that puts you at high risk for severe disease from COVID-19?			
17. FOR COVID VACCINE ONLY: I understand the benefits of COVID-19 vaccine are greatest for people 65 years and older and those under 65 years with a medical condition that puts them at most risk for serious COVID-19 disease. I understand the benefits of COVID-19 vaccine are lower for people without increased risk of COVID-19 disease.			

NURSE NOTES: _____

FINANCIAL

The cost of a billable service is the responsibility of the client/guarantor. Regular monthly payments are accepted to keep accounts from going into delinquent status. For unpaid balances a payment plan can be arranged with the clerical staff.

By signing, I consent to third party billing, including payment of government benefits to EIPH, and understand that services eligible for a sliding fee will be billed at 100% to third party payors.

INSURANCE (if applicable): As a courtesy, EIPH will bill your primary insurance for some services; however, ***EIPH is not a preferred provider for all insurances.*** It is recommended that you check with your health insurance regarding coverage. Client/guarantor will be billed for any remaining balances after insurance has been processed.

Medicare (if applicable): EIPH will bill Medicare Part B for flu and pneumonia vaccinations (and on a limited basis other vaccines). Most other Medicare covered vaccines are through Medicare Part D. EIPH will process Medicare Part D for coverage.

MEDICAL SERVICES/TREATMENT

- Healthcare at EIPH may be provided by a certified nurse midwife, physician, physician assistant, nurse practitioner, licensed nurse, or other qualified professional. I consent to examination, testing, and treatment. I also understand that I have the right to have my questions answered and the right to refuse any procedures or tests.
- I understand that immunizations are not mandatory and may be refused on religious or other grounds without reprisal. I understand information regarding vaccine(s) is available to me at EIPH. I understand the benefits and risks of vaccine(s) and ask that vaccine(s) be given to me or the person for whom I am authorized to make this request.
- I understand participation in and withdrawal from the immunization registry is voluntary. If you want to opt out or withdraw from Idaho’s immunization registry (IRIS), call the Idaho Immunization Program at 208.334.5931.
- I understand that in order to prevent injury from falling due to post-vaccination fainting, it is recommended that I sit in the lobby for 15 minutes before exiting the building.
- I authorize the release of my or my minor child’s (until 18 years) immunization records to clinics, physician offices, daycares and school. My authorization rights are available to me in EIPH’s Notice of Privacy Practices.
- I have been offered a copy of the Vaccine Information Statement(s) for all of the indicated age-appropriate vaccines that could be given. I have had a chance to ask questions and fully understand the benefits and risks of each indicated vaccine and I consent for me/my child to receive any vaccine(s) the Advisory Committee on Immunization Practices (ACIP) recommends at the present time.
- Since some medical conditions may affect my care, it is my responsibility to give as complete and accurate a medical history. If new problems that may be related to my condition or care arise, I understand I should inform the clinic. I understand that it is my responsibility to seek care elsewhere for any other medical problems beyond what is provided by the clinic.
- I understand that I have a right to refuse any procedures or services including Rapid HIV testing, that are recommended. Refusing some types of care will not jeopardize my receiving appropriate care for other problems or concerns.
- I know that all services provided by the clinic are confidential. I understand that the results of some tests for sexually transmitted infections and other diseases must be reported to the Health Department in a confidential manner, as required by law.
- Our services are confidential; however, if you are under the age of 18 and share with us a history of sexual or physical abuse or neglect, we are required by law to report this to the Department of Health and Welfare. Please ask us if you have any questions about these laws.

LEGAL STATUS ATTESTATION-applies only to individuals 18 years of age and older
I attest under penalty of perjury that I am a United States citizen, or a legal permanent resident, or am otherwise lawfully present in the United States pursuant to federal law.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)/PRIVACY PRACTICES

EIPH is required by law to maintain the privacy of your health information. Your information will be used for the purpose of treatment, payment, and EIPH business. You may request a copy of EIPH’s privacy practices at any time. Individuals who pay in full and out of pocket for an item or service may request that their protected health information is not shared with their health insurance or health plan.

If you believe your privacy rights have been violated, you may file a written complaint to the Secretary of the Department of Health and Human Services or to:
Privacy Officer: Eastern Idaho Public Health
1250 Hollipark Drive, Idaho Falls, ID 83401

By signing below, I confirm that I have:

- Read and understand the above information.
- Been offered a copy of EIPH’s HIPAA Privacy Practices.
- Been offered a copy of EIPH’s Financial Policy, and
- Been offered Vaccine Information Statements (if applicable).
- I am the parent or legal guardian of the minor child (as applicable)

Signature Date