

Please Print

Date (Fecha) _____ Arrival Time (Hora) _____ Client Sign In Number _____

_____) Reason for Visit _____
 Last Name (Apellido) _____ First Name (Nombre) _____ Middle Initial (Inicial) _____

Date of Birth (Fecha de Nacimiento-Month _____ Day _____ Year _____ Social Security (Seguro Social) _____ - _____ - _____

Immunization Program grant funding requires clients to report race and ethnicity of clients receiving services.

- | | | |
|---------------------------------|--|---|
| Sex/Gender assigned at birth | Race-Mark 1 or more | Ethnicity-Mark 1 |
| <input type="checkbox"/> Female | <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Hispanic or Latino |
| <input type="checkbox"/> Male | <input type="checkbox"/> Asian | <input type="checkbox"/> Not Hispanic or Latino |
| | <input type="checkbox"/> Black or African American | |
| | <input type="checkbox"/> Native Hawaiian or other Pacific Islander | |
| | <input type="checkbox"/> White | |

Address (Direccion) _____ Apartment Number (Numero de Apartamento) _____

City (Ciudad) _____ State (Estado) _____ Zip Code(Codigo Postal) _____ Preferred Phone (Telefono) _____

Email Address _____ Best time to call _____

For Immunization Services for Children

Adult's Name Accompanying Child: _____ Relationship to Child: _____

Grade & School Child Will Be Entering 2018-2019 School Yr.: _____

Vaccine for Children or other Immunization Eligibility for Services

- Are you covered by insurance? Yes No If yes, please have insurance card available.
- Medicaid Account Number _____
- Medicare Account Number _____
- Other _____ Account Number _____ Does this insurance cover shots Yes No

For office use only

Assessment Fee Collected _____

Entered into Florida Shots Forms Only Allergies _____ LMP _____

Only complete section below if FLShots entry done by someone other than RN that administered vaccine

Vaccine	Date Given	Brand Name	Mfr/Lot #	Route/Site	Signature/Title