

Hardin County Health Department
Demographic Information & Screening

(Please Print Full Name)

Last _____ First _____ Middle _____

Soc Sec # _____ DOB _____ Age ____ Sex ____ Race _____

Address _____ City/State/Zip _____ Phone _____

Mother's Full Maiden Name: _____

Please answer the following questions to the best of your knowledge:

1. Did you bring any immunization records with you today? Yes/No
(Please give any records that you have with this form once completed to staff)

2. If NO records please list name of facility where your child has received vaccines.

Facility Name	City/State	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please be advised that if you are depending on us to try and obtain your child's immunizations records from other facilities that there may be a wait.

NO vaccines will be given without a complete immunization record to children under the age of 18 years.

By signing below you are authorizing Hardin County Health Department to administer services to you.

Signing below states you have received the Health Insurance Portability and Accountability Act (HIPPA) Privacy Notice.

Signature _____