

**Trumbull Health Department**

**335 White Plains Road, Trumbull, CT 06611**

**Phone (203) 452-1030 Fax (203) 452-1050**

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**Last Name First Name Date of Birth Age Gender**

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**Address City/State/Zip Code Phone**

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**Primary Care Physician (optional) Parent Name (if minor)**

**Please review:**

* I understand that **if my insurance denies payment** I will be billed for these services.
* I have reviewed a copy of the **Trumbull Health Department’s Notice of Privacy Practices & HIPAA Statement**. I understand I can ask for a physical copy.
* I received a copy or was given the QR code to the **Vaccine Information Statement (VIS)** for the vaccines received today.
* I understand that ALL vaccines are reported to the **State of Connecticut’s vaccine database (CTWiz)**. If I choose to opt out, I understand I can be given instructions on how to do so.
* I understand that the Trumbull Health Department has the **right to refuse to vaccinate anyone** if the THD, its agents, or employees deem that in their discretion, the client or anyone with them is uncooperative and attempting to vaccinate could lead to a safety issue for the vaccinator, the client, or others in the vicinity.
* I give permission to have my/my child’s **record sent to my/their medical provider and school** as needed.
* By signing below, I verify that I have reviewed the information on the **front and back** of this page.

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Patient/Parent/Guardian Signature Date

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If signed by a parent/guardian, please print your name and relationship to the patient.

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Public Health Nurse Signature Date

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Reviewed (2nd Visit) Date Public Health Nurse Date

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Reviewed (3rd Visit) Date Public Health Nurse Date

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Reviewed (4th Visit) Date Public Health Nurse Date

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Reviewed (5th Visit) Date Public Health Nurse Date

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Reviewed (6th Visit) Date Public Health Nurse Date

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