Cheyenne Laramie County Public Health

2026-2027 Seasonal Vaccine Form

Patient Full Name:	Date of Birth:	Age:	Sex: (circle) Male or Female	
Address:	City:	State:	Zip Code:	Telephone:
Emergency Contact Name:	Emergency Contact Telephone:		Relationship to Patient:	
Primary Insurance Company Name:	Policy Number:	Name of Insured:	Insured Telephone:	
Insured Date of Birth	Relationship to Patient	Address of Insurance Company		
Secondary Insurance Company Name:	Secondary Policy Number:	Name of Insured:	Insured Telephone:	
Insured Date of Birth	Relationship to Patient	Address of Insurance Company		

Screening Questionnaire & Vaccine Consent

1. Are you sick today?	☐Yes ☐ No ☐ Don't Know
2. Do you have allergies to medications, food, a vaccine component, or latex??	☐Yes ☐ No ☐ Don't Know
3. Have you ever had a serious reaction after receiving a vaccination?	☐Yes ☐ No ☐ Don't Know
4. Have you ever had Guillain-Barré syndrome?	☐Yes ☐ No ☐ Don't Know
5. Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19	☐Yes ☐ No ☐ Don't Know
6. Are you Pregnant?	☐Yes ☐ No ☐ Don't Know
7. Have you ever felt dizzy or faint before, during, or after a shot?	☐Yes ☐ No ☐ Don't Know
8. Are you anxious about getting a shot today?	☐Yes ☐ No ☐ Don't Know
9. Have you ever received a RSV vaccine before?	☐Yes ☐ No ☐ Don't Know
10. For patients age 50-74: Do you have a chronic medical condition such as lung disease, asthma, heart failure, diabetes, kidney disease or weakened immune system?	☐Yes ☐ No ☐ Don't Know

Initial for Consent	Vaccine Type
	Flu Vaccine (Ages 6mon to 64 years) or ***uninsured***
	Flu Vaccine High Dose (Ages 65 and older)
	RSV (Arexvy) (Ages 60 and older)
	Covid-19 (Pfizer Monovalent 25-26 season) ***5-11years***
	Covid-19 (Pfizer 25-26 season) **12 years and up**

In Network Insurance Providers: Aetna, First Choice Health, Blue Cross Blue Shield, United Healthcare, UMR, Great West/Cigna, WY Medicaid, Medicare and Tricare.

I, _____ consent myself or child (_____) to receive the above immunizations by Cheyenne Laramie County Public Health. I understand that immunizations will only be given if indicated by immunization history, age, and health screening questionnaire. In addition, I read or have had explained to me and understand the Vaccine Information Statement(s) for the vaccine(s) that the PHN is administering today. A healthcare professional also provided education and counseling on each vaccine and thoroughly answered my questions. I have been advised to wait for 15 minutes of observation after receiving the vaccination(s). My signature below is my authorization for the release of information necessary to process my claim(s) to insurance or another payer. In addition, I agree to pay all fees not covered by insurance.

Notice of Privacy Practices: Acknowledgement of Receipt

The Notice of Privacy explains how the Wyoming Department of Health may use or disclose information. Not all situations may be described. WDH is required to furnish its clients with a notice of privacy practices pertaining to information use, maintain, and disclose.

My signature below consents myself or child to vaccines initialed on this form. My signature below is also my authorization for the release of information necessary to process my claim(s) to insurance or another payer. In addition, I agree to pay all fees not covered by insurance. I have received a copy of the WDH Notice of Privacy Practices and have had an opportunity to ask questions regarding how my information will be used.

_____ _____

(Signature) (Date)

_____ _____

(Name of Personal Representative if Applicable) (Relationship to Client)

CHEYENNE LARAMIE COUNTY PUBLIC HEALTH OFFICIAL USE ONLY

Clinic Location:	**Date and Time of Administration:**	**RN Signature:**	
Flu Vaccine **CPT CODE** **Flulaval: 90656** **High Dose: 90662**	**Location of Injection (circle)** RDT LDT	**Stock Type (Circle)** VFC/WyVIP Private	Place Sticker Here
RSV **CPT Code: 90679**	**Location of Injection (circle)** RDT LDT	**Stock Type (Circle)** VFC/WyVIP Private	Place Sticker Here
COVID 19 **5-11 yo:91319** **12yo+: 91320**	**Location of Injection (circle)** RDT LDT	**Stock Type (Circle)** VFC/WyVIP Private	Place Sticker Here

Entered into WyIR: _____

Billed in CureMD: _____

Scanned in CureMD: _____