AUGLAIZE COUNTY HEALTH DEPARTMENT

prevent. promote. protect.

*** Please complete both sides of form ***

Adult (19+ older) Vaccine Administration Form

Date: / /

Name: Last, First, MI			Date of Birth	Age
Address	City	State	Zip	County
Phone	Sex	Race	Client's SS#	Marital Status

		Yes	No
1.	Are you sick today?	☐	☐
2.	Do you have allergies to medications, food, a vaccine component, or latex?	☐	☐
3.	Have you ever had a serious reaction after receiving a vaccination?	☐	☐
4.	Do you have a long term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Are you on long term aspirin therapy?	☐	☐
5.	Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐
6.	Have you had a seizure or a brain or other nervous system problem?	☐	☐
7.	In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☐
8.	During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐
9.	For Women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐
10.	Have you received any vaccinations (including COVID-19 vaccine) in the past 4 weeks?	☐	☐
11.	a. Does this client have health insurance from an employer or privately purchased? b. Does this insurance pay for immunizations?	☐ ☐	☐ ☐
12.	Does this client have Medicaid or insurance through Job & Family Services?	☐	☐
13.	Does this client have Medicare or Medicare Advantage Plan?	☐	☐

AUGLAIZE COUNTY HEALTH DEPARTMENT STAFF USE ONLY

Vaccine declined when recommended: _____ **Education and information provided:** ☐

***Return Date & Time** _____

		Vaccine/VIS	Date Given	Manufacturer	Lot#	Injection Site	Administrator
V	P					LT RT LD RD PO	
V	P					LT RT LD RD PO	
V	P					LT RT LD RD PO	
V	P					LT RT LD RD PO	
V	P					LT RT LD RD PO	
V	P					LT RT LD RD PO	

TOTAL CHARGE: $ _____

INSURANCE INFORMATION _____

Patient Financial Responsibility Form

Father/Guardian			Mother/Guardian		
Name:			Name:		
Date of Birth:			Date of Birth:		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Phone:			Phone:		

Primary Insurance

Name of Insurance:	Policy Holder's Name:
Policy Holder's Home Address:	
Relationship to Patient:	Policy Holder's Employer:
Policy Holder's Phone #:	Policy Holder's Date of Birth:

Is Patient Covered by any additional insurance? **Yes (*)** **No**

Secondary Insurance (*)

Name of Insurance:	Policy Holder's Name:
Policy Holder's Home Address:	
Relationship to Patient:	Policy Holder's Employer:
Policy Holder's Phone #:	Policy Holder's Date of Birth:

- **Authorization to pay benefits to Auglaize County Health Department (ACHD):** I authorize payment be made directly to ACHD for medical services provided to me or my family members.
- I authorize the release of any medical or other information necessary to process this claim.
- I understand that I will assume full responsibility for payment for services, if my insurance denies or does not cover my claim for services rendered at ACHD. I accept financial responsibility with or without the use of insurance coverage.
- I understand that I am responsible for notifying the ACHD if there is a change in the insurance coverage or funding status.
- **Deductible:** I understand that if my insurance carrier determines that I have not met my deductible, that I will be fully responsible for payment in a timely manner. Payment will be made within 30 days of notification by my insurance carrier or ACHD
- I understand I am responsible for all charges incurred by not providing the most current, correct insurance information to the ACHD.
- **Sliding Fee Scale Agreement:** If payment for services is determined by and based on a sliding fee scale. I understand that I am responsible for my share of the cost of service rendered.

IMMUNIZATION CONSENT FORM

*I acknowledge having a chance to review & keep the Auglaize County Health Department (ACHD) Notice of Privacy Practices. Copies of the Privacy Notice are displayed in the Health Department. I understand the terms of the Privacy Notice may change and I may get these changed notices by contacting ACHD by phone or in writing. I understand I have the right to ask how my protected health information will be used and / or given out.
*I understand ACHD may disclose my protected health information for the purposes of treatment, payment and operations of my health care and this clinic. **Examples of entities requesting information:**

Parent or Guardian	Help Me Grow	Insurance Carriers	Schools / Preschools	Daycare or Head Start
State of Ohio Immunization Registry		Job & Family Services	Other Health Departments	WIC

*I understand an appointment reminder or missed appointment notice may be sent by postcard or letter in the mail, telephone / answering machine or voicemail, or text message.
* I understand ACHD utilizes the ACIP Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger and the Recommended Adult Immunization Schedule for ages 19 years or older published by the CDC. I understand combination vaccine may be utilized.
*I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after vaccination.
*I hereby give consent to the Auglaize County Health Department staff to administer the requested / determined vaccination(s) to myself or the person named for whom I am authorized to make this request (as Parent/Guardian). I have received a copy of the most up to date Vaccine Information Statement(s) for the vaccine(s) to be given and have had the opportunity to ask questions and have them answered to my satisfaction. I understand the benefits / risks associated with the vaccines to be given. Further, for observation by the administering healthcare provider

SIGN **Patient**/Parent/Legal Guardian Name: _____ Date: _____

Relationship to Patient: _____

**********AUGLAIZE COUNTY HEALTH DEPARTMENT (STAFF USE ONLY) **********

Possible Risks & Reactions Discussed? Yes No _____ (Signature of Reviewer)

Revised 11-12-2019