



AUGLAIZE COUNTY
HEALTH DEPARTMENT

prevent. promote. protect.

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

Adult (19+ older)
Vaccine Administration Form

Date: / /
Age

Name: Last, First, MI		Client's SS#		Date of Birth		Age	
Address			City		State	Zip	County
Phone		Text Msg # (For Appt. Reminders)		Sex	Race	Doctor	

		Yes	No
1.	Are you sick today?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Do you have allergies to medications, food, a vaccine component, or latex?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Have you ever had a serious reaction to a vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Do you have a long term health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, blood disorder, no spleen, complement component deficiency, a cochlear implant or a spinal fluid leak? On long-term aspirin?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Do you have cancer, leukemia, HIV/AIDS? Do you or a parent or sibling have an immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Have you had a seizure; brain or other nervous system problems?	<input type="checkbox"/>	<input type="checkbox"/>
9.	In the past 3 months, have you taken medications that weaken 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?	<input type="checkbox"/>	<input type="checkbox"/>
10.	During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	<input type="checkbox"/>	<input type="checkbox"/>
11.	For Women: Are you pregnant or is there a chance you could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>
12.	Have you received vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>
14.	a. Does this client have health insurance from an employer or privately purchased?	<input type="checkbox"/>	<input type="checkbox"/>
	b. Does this insurance pay for immunizations?	<input type="checkbox"/>	<input type="checkbox"/>
15.	Does this client have Medicaid or insurance through Job & Family Services?	<input type="checkbox"/>	<input type="checkbox"/>
16.	Does this client have Medicare or Medicare Advantage Plan?	<input type="checkbox"/>	<input type="checkbox"/>

AUGLAIZE COUNTY HEALTH DEPARTMENT STAFF USE ONLY

Vaccine declined when recommended: _____ Education and information provided:

		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	
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.

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)