



**AUGLAIZE COUNTY**  
HEALTH DEPARTMENT  
*prevent. promote. protect.*

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

**Pediatric (0-18 Years)  
Vaccine Administration Form**

Date: / /  
Age

Name: Last, First, MI			Date of Birth		Age	
Address			City	State	Zip	County
Phone	Sex	Race	For Children – Mother's Name			
Client's SS#	Pediatrician/Doctor		For Children - Father's Name			

Yes No

1.	Is the child sick today?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Does the child have allergies to medications, food, a vaccine component, or latex?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Has the child had a serious reaction to a vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, a cochlear implant or a spinal fluid leak? Is he/she on long-term aspirin therapy?	<input type="checkbox"/>	<input type="checkbox"/>
5.	If the child to be vaccinated is between the ages of 2 through 4 years, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
6.	If your child is a baby, have you ever been told he/she has had intussusception?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Does the child or a family member have cancer, leukemia, HIV/AIDS, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>
9.	In the past 3 months, has the child taken medications that affect the 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.	In the past year, has the child 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.	Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>
12.	Has the child received vaccinations (including COVID-19 vaccine) in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>
13.	Is the client an American Indian or Alaska Native?	<input type="checkbox"/>	<input type="checkbox"/>
14.	a. Does this client have health insurance from an employer or privately purchased? 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.	This client would like referral to: (please circle) 1) WIC 2) Help Me Grow 3) BCMH	<input type="checkbox"/>	<input type="checkbox"/>

**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	
V P					LT RT LD RD PO	

TOTAL CHARGE: \$ \_\_\_\_\_

INSURANCE INFORMATION \_\_\_\_\_

## Patient Financial Responsibility Form

### Father/Guardian

Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_

### Mother/Guardian

Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 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)