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

Pediatric (0-18 Years) Vaccine Administration Form

Date: / /

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

#	Question	Yes	No
1.	Is the child sick today?	☐	☐
2.	Does the child have allergies to medications, food, a vaccine component, or latex?	☐	☐
3.	Has the child had a serious reaction to a vaccine in the past?	☐	☐
4.	Does the child have a long-term health problem: lung, heart, kidney, metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, spinal fluid leak? Long-term aspirin therapy?	☐	☐
5.	If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐	☐
6.	If your child is a baby, have you ever been told he/she has had intussusception?	☐	☐
7.	Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐	☐
8.	Does the child have cancer, leukemia, HIV/AIDS? Does the child or a parent or sibling have an immune system problem?	☐	☐
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 had radiation treatment?	☐	☐
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?	☐	☐
11.	Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐
12.	Has the child received vaccinations in the past 4 weeks?	☐	☐
13.	Is the client an American Indian or Alaska Native?	☐	☐
14.	a. Does this client have health insurance from an employer or privately purchased?	☐	☐
	b. Does this insurance pay for immunizations?	☐	☐
15.	Does this client have Medicaid or insurance through Job & Family Services?	☐	☐
16.	This client would like referral to: (please circle) 1) WIC 2) Help Me Grow 3) BCMH	☐	☐

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)**