Immunization Clinic
Screening and Consent Form

PATIENT NAME: ______________________________ **BIRTHDATE:** ________________

Please initial next to each vaccine that you wish for you/your minor child to receive at the Morrow County Health District Immunization Clinic.

______ DTaP

______ Hib

______ Polio

______ Hepatitis B

______ Pneumococcal

______ Rotavirus

______ Flu

______ MMR (Measles, Mumps, Rubella)

______ Varicella (Chickenpox)

______ Hepatitis A

______ Tdap

______ Meningococcal

______ HPV (Human Papillomavirus)

______ Td

______ TB test

I have been provided a copy of the Vaccine Information Sheet(s) and have had an opportunity to have all of my questions answered to my satisfaction. I believe that I understand the risks and benefits of the vaccine(s) and ask that the vaccine(s) initialed above be given to me or the person named on this form. If the person receiving vaccines is a minor, I certify that I am a parent or legal guardian and am authorized to consent to these services. I grant permission for record of the vaccine(s) given to be entered into the state immunization registry. I have read a copy of the Morrow County Health District's Privacy Practice and understand how my protected health information (PHI) may be used. I grant permission for Morrow County Health District to request and receive vaccine records from previous providers as needed.

Patient or Parent/Guardian Signature: ______________________________ **Date:** ____________

Screening Checklist for Contraindications to Vaccines for Children and Teens

PATIENT NAME ____________________

DATE OF BIRTH ___/___/___ (month / day / year)

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
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 with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Is he/she on 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 or 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, or any other immune system problem?	☐	☐	☐
9. Does the child have a parent, brother, or sister with an immune system problem?	☐	☐	☐
10. 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 treatments?	☐	☐	☐
11. 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?	☐	☐	☐
12. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐	☐
13. Has the child received vaccinations in the past 4 weeks?	☐	☐	☐

FORM COMPLETED BY ____________________ DATE ________

FORM REVIEWED BY ____________________ DATE ________

Did you bring your immunization record card with you? yes ☐ no ☐

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.

Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

www.immunize.org/catg.d/p4060.pdf • Item #P4060 (10/20)

DEMOGRAPHIC FORM

(Please Print)

Today's date:

PATIENT INFORMATION

Patient's last name: | First: | Middle: | ☐ Mr. ☐ Mrs. | ☐ Miss ☐ Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ☐ Yes ☐ No | If not, what is your legal name? | (Former name): | Birth date: / / | Age: | Sex: ☐ M ☐ F

Street address: | Social Security no.: | Home phone no.: ( )

P.O. box: | City: | State: | ZIP Code:

Occupation: | Employer: | Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):

☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages ☐ Other

Other family members seen here:

INSURANCE INFORMATION

Person responsible for bill: | Birth date: / / | Address (if different): | Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation: | Employer: | Employer address: | Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Name of primary insurance: | Subscriber's name: | Group no.: | Policy no.:

Subscriber's name: | Subscriber's S.S. no.: | Birth date: / / | Group no.: | Policy no.: | Co-payment: $

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable): | Subscriber's name: | Group no.: | Policy no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IF APPLYING FOR A FINANCIAL HARDSHIP DISCOUNT:

I state that there are ______ people living in my household and the combined household income is $ _________ per (circle one): week every 2 weeks month year

Do your currently receive any public financial assistance such as WIC, SNAP, or TANF? Circle one: Yes No

AUTHORIZATIONS AND AGREEMENTS

Emergency Contact: Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( )

The above information is true to the best of my knowledge. I request and authorize the Practice and its personnel to deliver medical care to me or my child listed above. I further authorize my insurance benefits be paid directly to the provider. I have received the Patient Financial Policies and understand that I am financially responsible for any balance. I also authorize Morrow County Health District or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

September 2014

MORROW COUNTY HEALTH DEPARTMENT AUTHORIZATION FOR THE RELEASE OF PERSONAL HEALTH INFORMATION

I have received a copy of the Notice of Privacy Practices and my questions have been answered.

PRINT YOUR NAME: *(person completing form)*

____
LAST FIRST Middle Initial

RELATIONSHIP TO PATIENT:

- ☐ Self
- ☐ Custodial parent/legal guardian of child
- ☐ Legal guardian of adult
- ☐ Medical power of attorney
- ☐ Other_______________________

PATIENT NAME: *(if different than above)*

____
LAST FIRST Middle Initial

PATIENT ADDRESS:

____
Street Address *(w/ apt. no. if applicable)*

_______________________ _____________
City Zip

PATIENT PHONE: __(_____)____________________

I authorize the release of information to the patient and the following **FAMILY MEMBERS**:

____

____

I prefer you **CONTACT ME** via:

- ☐ Cell phone: __(_____)__________________
- ☐ Home phone: __(_____)__________________
- ☐ Work phone: __(_____)__________________
- ☐ Text message: __(_____)__________________
- ☐ Email: ______________________________
- ☐ Mailing address:

____
City_________________ State____ Zip________

If the Health Department can't reach me directly by mail or phone, I authorize the staff to contact the following person(s) to obtain my current contact information.

ALTERNATE CONTACT PERSON'S NAME:

____
LAST FIRST Middle Initial

ALTERNATE CONTACT'S ADDRESS:

____
Street Address *(w/ apt. no. if applicable)*

_______________________ _____________
City Zip

ALTERNATE CONTACT'S PHONE:__(_____)__________

RELEASE TO SHARE INFORMATION:

I hereby give permission for the Morrow County Health District to obtain and/or release information as described in the MCHD Notice of Privacy Practices to provide services. As required to provide services, MCHD may request or release:

- ☑ Health records
- ☑ Insurance status or covered benefits
- ☑ Income verification
- ☑ Medical birth information *(add'l form required)*

From or To:

- ☑ Physician of record
- ☑ Specialty physician
- ☑ Other treating healthcare facility or provider
- ☑ Referring agency
- ☑ Ohio Department of Health
- ☑ Other agencies providing care/service
- ☑ Third party payer *(e.g. health insurance)*

I understand that I may restrict how MCHD shares information by striking any of the items listed above or attaching separate instructions. However, MCHD cannot bill for services on my behalf without sharing information with the payer; in that case I will have to pay MCHD at the time of service. Further, I understand that MCHD may not have the information it needs to determine eligibility or provide me with services if I restrict certain information. I understand that I will be notified if my restrictions affect MCHD service delivery. I understand that MCHD must release information as required by law.

SIGNATURE:_____________________________

DATE: _____/_____/_______ *(expires 2 years after this date)*

WITNESS SIGNATURE:_____________________________

DATE: _____/_____/_______ *(expires 2 years after this date)*