AUGLAIZE COUNTY HEALTH DEPARTMENT

prevent. promote. protect.

*** 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	

		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.	Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? 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/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 or a family member have cancer, leukemia, HIV/AIDS, or any other 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:** ☐

***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 _____

REVISED 03-02-2018 /S:/FORMS/IMM VACCINE

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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 the Auglaize County Health Department 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	WIC	State of Ohio Immunization Registry
Daycare or Head Start	Job & Family Services	Other Health Departments

*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 / email.

*I grant permission to the Auglaize County Health Department to give 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 the Vaccine Information Statements for the vaccine(s) noted and have had the opportunity to ask questions concerning the vaccines to be given. I understand the benefits / risks associated with the vaccines to be given.

X_____Date_____

****
****

AUGLAIZE COUNTY HEALTH DEPARTMENT STAFF USE ONLY

Possible Risks & Reactions Discussed? Yes No _____

(Signature of Reviewer)

04/26/2017

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:** I authorize payment be made directly to the Auglaize County Health Department for medical services provided to me or my family members.
- 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 Auglaize County Health Department. I accept financial responsibility with or without the use of insurance coverage.
- I understand that I am responsible for notifying the Auglaize County Health Department 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 Auglaize County Health Department.
- I understand I am responsible for all charges incurred by not providing the most current, correct insurance information to the Auglaize County Health Department.
- **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.

X Print Patient's Name: _____ Date: _____

X Sign Patient/Parent/Legal Guardian Name: _____

Relationship to Patient: _____

Staff Signature: _____ Date: _____

REV. 4/25/17 (Pediatric)