Ashland County Health Department

1211 Claremont Avenue
Ashland, Ohio 44805

Please write legibly* *_ALL_ Fields are required to be filled out

Patient's name: _____ Birthdate: _____ Age: _____

Parent/Guardian name (for minors): _____ Patient's Social Security #: _____

Home Address: _____ Race: _____ Sex: M F Other: _____

City: _____ State: _____ Zip Code: _____ Ethnicity: ○ Hispanic ○ Non-Hispanic ○ Not Specified

Email: _____ Phone Number: _____

Emergency Contact (**NOT person signing today**): _____ Emergency Contact Birthdate: _____

Relationship (to patient): _____ Emergency Contact Phone Number: _____

Patient's Primary Doctor or where do you seek Medical Care: _____

Employer or school: _____

Medical insurance company: _____

_____ My insurance does not cover vaccines _____ My employer/school is paying for my vaccines

Please have ready for registration:

1. Vaccine record of the person receiving vaccines today.
2. Insurance Card
3. Driver's license or ID card of responsible party

Acknowledgement of Financial Responsibility

I understand that my insurance will be billed for services that I/my child receives at the Ashland County Health Department and that I am responsible for any co-pay or deductible imposed by, or charges not covered by my policy. Any outstanding invoices not paid within 90 days will be sent to a collection agency. Each insurance policy is unique, and I understand that some services may not be covered.
Please check on of the following:

_____ I give my permission to bill my insurance provider for services.

_____ I do NOT give permission to bill my insurance and will self-pay for all services provided to me or my child.

_____ The above-named patient has no insurance coverage.

I attest that the information provided is accurate, to the best of my knowledge.

Signature: _____ Date: _____

Witness: _____ Date: _____
(Witness will be a ACHD Staff Member)

Office use only:
Amount Paid: _____ cash _____ check# _____ credit/debit _____ Insurance to be billed: _____
VFC eligible (age 18 and under) Yes No Employer/School to be billed: _____
Adult eligible for ODH vaccine _____ NC (unable to pay) _____ Insurance verified by _____ Clerk initials: _____
_____ Receipt #

Ashland County Health Department
Screening Questionnaire for Child Immunization (0-18 years)

Patient's Name: _____ **Date of Birth:** _____

*If you answer yes to any of the following questions, please provide an explanation.	YES	NO
1. Is the child sick today?		
2. Is the child on any medications? List:		
3. Does the child have allergies to medications, food, a vaccine component, or latex?		
4. Has the child ever had a serious reaction to a vaccine in the past?		
5. Has the child ever had a seizure, brain/neurological disorder, other nervous system disorder, or Guillain-Barre?		
6. Does the child have a health problem with heart, lung, asthma, kidney, or metabolic disease (e.g., diabetes), anemia, or other blood disorder?		
7. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?		
8. 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?		
9. During the **past year**, has the child received a transfusion of blood, blood products, or been given immune (gamma) globulin or an antiviral drug?		
10. Is the child/teen pregnant or is there a chance she could become pregnant during the **next month**?		
11. In the **past 4 weeks**, has the child received any vaccinations (including Flu Mist)?		
12. If your child is a baby, have you ever been told he or she has intussusception?		
13. Has the child (age 6 years and younger) ever had a blood test for lead poisoning?		
14. Has the child ever had chicken pox (illness)?		
15. Will the child be traveling out of the United States in the near future?		

****Please bring a vaccine record with you *every time* ****

Health Insurance Status/VFC Eligibility

The Vaccines for Children (VFC) program is funded by the U.S. Government. To determine eligibility:	YES	NO
Is your child enrolled in Medicaid/Healthy Start?		
Is your child currently **without any** health insurance?		
Is your child a ***registered*** American Indian or Alaskan Native?		
Does your child have insurance that does **not** cover vaccines?		

Consent for Vaccination

I have read or had read to me the information in the appropriate Vaccine Information Statement (VIS). I've been given the chance to ask questions which were answered to my satisfaction. I am informed of the benefits and risks of the vaccine. I request vaccine(s) be administered to me or the person above whom I am authorized to sign as their parent or guardian.
I have had an opportunity to receive a copy of the Ashland County Health Department's Notice of Privacy Practices.
I grant permission for this record to be released to the child's medical provider, school, day care center, WIC, other health department, Ohio Department of Health (ODH), and the state immunization registry, as is required or necessary.

Patient/Parent/Guardian: _____ **Date:** _____

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********** FOR HEALTH DEPARTMENT NURSE **********

_____ **Immunization** history has been reviewed to determine the vaccines which are indicated for the child's age.
_____ **Screening** Questionnaire was reviewed, & no contraindications to the above vaccines have been found.
_____ VIS (s) was given and reviewed with parent; questions have been addressed.
_____ Parent has been given a reminder slip with the return date of: _____

_____

RN Signature