# Ashland County Health Department

1211 Claremont Avenue
Ashland, Ohio 44805

***Please write legibly* ****ALL*** **Fields are required to be filled in***

Patient's name: ______________________ Birthdate: ____________ Age: ________

Maiden Name: ________________ Race: __________ Social Security # ____________

Home address: ______________________________ Sex: M F Other: ________

City: ______________ State: ______ Zip Code: __________ Ethnicity: ○ Hispanic ○ Non-Hispanic ○ Not Specified

Email: ______________________________ Phone Number: ________________

Emergency Contact: __________________________ Emergency Contact Birthdate: ____________

Relationship (to patient): ______________ Emergency Contact Phone Number: ________________

Patient's Primary Doctor: ______________________________________

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 receive 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 one 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 is an 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 Adult Immunization (19+ years)**

**Patient Name:** ______________________________ **Date of Birth:** ____________________

| *If you answer yes to any of the following questions, please provide an explanation | Yes | No |
|---|---|---|
| 1. Are you sick today? | | |
| 2. Have you ever felt dizzy or faint before, during, or after a shot? | | |
| 3. Are you anxious about getting a shot today? | | |
| 4. Do you have allergies to medications, food, a vaccine component, or latex? List: | | |
| 5. Have you ever had a serious reaction after receiving a vaccine? | | |
| 6. Have you had a seizure or a brain or other nervous system problem? | | |
| 7. Do you have any of the following: a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? | | |
| 8. Are you on long-term aspirin therapy? | | |
| 9. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? | | |
| 10. Do you have a parent, brother, or sister with an immune system problem? | | |
| 11 In the **past 6 months**, have you taken medications that affect your 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? | | |
| 12. Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes Covid-19? | | |
| 13. During the **past year**, have you received immune (gamma) globulin, blood/blood products, or an antiviral drug? | | |
| 14. For women: Are you pregnant or is there a chance you could become pregnant during the **next month**? | | |
| 15. Have you received any vaccinations in the past 4 weeks? | | |
| 16. Have you ever had chicken pox (illness)? | | |
| 17. Do you plan to travel out of the United States in the next 6 months? | | |
| 18. Are you currently covered by Medicaid? | | |
| 19. Do you have private 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 legal 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 my medical provider, another health department, Ohio Department of Health (ODH), and the state immunization registry, as is necessary.

**Signature:** ______________________________ **Date:** ____________________

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

________ **Immunization** history has been reviewed to determine the vaccines which are indicated for the client.
________ **Screening** Questionnaire was reviewed, & no contraindications to the above vaccines have been found.
________ VIS (s) was given and reviewed with client; questions have been addressed.
________ Client has been given a reminder slip with the return date of: ________________
________ Next appointment date: ________________ Time: ________________

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

______________________________
**RN Signature**