Franklin County Public Health
280 East Broad Street
Columbus, Ohio 43215-4562
(614) 525-3160
www.myfcph.org

Client Registration/Consent Form

Immunization Program

Office Use Only	Date: □ ID Check
	□ Canal □Clinton □ Dublin □ FCPH □ Gahanna □ Grove City
	□ Norwich □ Prairie □ Reynoldsburg □ Westerville □ Whitehall

Person receiving vaccine

First Name	MI	Last Name		
Address	City		State	Zip
Phone	Email			
Date of Birth (MM/DD/YYYY)	Age	Gender □ Male □ Female		

Primary Language □ English □ Spanish □Chinese □ Other:_____

Race (check all that apply): □ Asian □ Black/African American □ White □ Native American or Alaskan Native □ Other:_____

Ethnicity: □ Hispanic or Latino □ non-Hispanic or Latino

Parent or Legal Guardian (if applicable)

First Name	Last Name
Relationship to Client	Phone

Screening Questions for person receiving vaccine (Please Circle)

1. Sick today?		YES	NO
2. Have allergies to any medications, food, latex or vaccines?		YES	NO
3. Any serious reactions after receiving vaccines in the past?		YES	NO
4. Had a seizure, or brain or other nervous system problem?		YES	NO
5. Have cancer, leukemia, AIDS, or any other immune system problems?		YES	NO
6. In the past 3 months, taken medications that affect the immune system, such as cortisone, prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?		YES	NO
7. Received a transfusion of blood or blood products, or been given immune (gamma) globulin in the past year?		YES	NO
8. Pregnant or is there a chance of becoming pregnant in the next month?		YES	NO
9. Received vaccinations in the last month?		YES	NO
10. Will you be getting a TB test in the next month?		YES	NO
11. If under 8 months old, has the baby ever had intussusception (a rare type of intestinal blockage)?	Not Applicable	YES	NO

Doctor Information

Have a Doctor? □ No □ Yes, **Name:** _____ **Location:** _____

OVER→

Payment Information

Do you have Health Insurance? □ No □ Yes

If Yes, name of Primary Insurance_____

Insurance Subscriber's First and Last Name:_____

Insurance Subscriber's Date of Birth:_____ **Gender: □ Male □ Female**

name of Secondary Insurance (if applicable)_____

Initials_____ **Financial Responsibility Statement- Initial if we are billing your insurance**

I agree to promptly pay with settlement in full for the medical services provided to myself and/or minor child at the prevailing rates as bill are presented. I understand that I am financially responsible for all the charges that are not covered by my insurance plan. I authorize FCPH to submit a claim to my insurance carrier and I authorize payment directly to FCPH.

Medical Message Permission

May we leave a detailed message on your voicemail/email regarding any medical/clinic information?
□ Yes □ No

Consent for Treatment

To the best of my knowledge, I understand the benefits and/or risks of vaccines. I hereby give consent to Franklin County Public Health (FCPH) staff for the administration of the vaccine to myself or for the individual for whom I am authorized to make said request. I have received a copy of the most up-to-date Vaccine Information Statement (VIS). I understand that I will have the chance to ask questions and have them answered to my satisfaction. I acknowledge that I have been offered and/or received the FCPH Notice of Privacy Practice Summary (HIPAA), which explains policies concerning my personal health information. FCPH is authorized to release vaccination information to schools, day cares, and/or others as necessary or required for treatment of care and billing purposes.

Signature:	**Date:**
Relationship to Client:	

**** STOP ** OFFICE USE ONLY** *

Consent shown/given (if not parent or guardian): □ Attached/scanned □ Given via phone

V / P / A	#	Fee	Lot #		#	Fee	Lot #		#	Fee	Lot #
HepB ped				Kinrix				Td			
Pentacel				ProQuad				HepA-Adult			
Pediarix				Polio				HepB-Adult			
Prevnar 13				Tdap				Twinrix			
Rotarix				Gardasil				Pneumo 23			
DTaP				Menactra				Shingles			
Hib				Bexsero				Flu-High			
MMR				Flu- 0.5ml							
Varicella											
HepA-ped											
Flu-Ped											

□ Client advised to stay □ Will Call □MOGE:

Due:_____ **□ Appt:**_____

Needs:_____ **Clinic:**_____

FCPH Witness:	**Date:**
	Total Charge Ticket Fee = $