**Person receiving vaccine**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>M.I.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Date (MM/DD/YYYY)</td>
<td>Age</td>
<td>Gender</td>
</tr>
<tr>
<td>Street Address</td>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Race (check all that apply):</td>
<td>Asian</td>
<td>Black/African American</td>
</tr>
<tr>
<td>Preferred Language</td>
<td>English</td>
<td>Spanish</td>
</tr>
<tr>
<td>Ethnicity:</td>
<td>Hispanic or Latino</td>
<td>non-Hispanic or Latino</td>
</tr>
</tbody>
</table>

**Screening Questions for person receiving vaccine (Please Circle)**

1. Sick today?  
2. Have allergies to any medications, food, latex or vaccines?  
3. Any serious reactions after receiving vaccines in the past?  
4. Had a seizure, or brain or other nervous system problem?  
5. Have cancer, leukemia, AIDS, or any other immune system problems?  
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?  
7. Received a transfusion of blood or blood products, or been given immune (gamma) globulin in the past year?  
8. Pregnant or is there a chance of becoming pregnant in the next month?  
9. Received vaccinations in the last month?  
10. Will you be getting a TB test in the next month?  
11. If under 8 months old, has the baby ever had intussusception (a rare type of intestinal blockage)?  

**Doctor Information**

Have a Doctor?  
Primary Care's Location: ___________________
Payment Information

Patient Name: ___________________________

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

Notice, Release, and Waiver of Liability

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 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: ___________________________

Notice, Release, and Waiver of Liability

I, the undersigned, voluntarily agree to obtain services or engage with Franklin County District Board of Health, its officers, agents, independent contractors, and/or employees on the date indicated below.

HEALTH AND SAFETY REQUIREMENTS. By signing below, I hereby understand and agree to abide by all public health orders and requirements issued by the federal government, State of Ohio, and local government entities while obtaining services or engaging with Franklin County District Board of Health. Such orders include, but are not limited to, all Orders issued by the Director of the Ohio Department of Health. I also agree to abide by all health and safety requirements mandated by Franklin County District Board of Health, its agents, independent contractors, and/or employees. Franklin County District Board of Health hereby requires all individuals entering onto Franklin County District Board of Health property to abide by the following guidelines:

• **Masks.** All individuals are expected to use facial coverings when inside or on the premises of Franklin County District Board of Health. Masks may be temporarily removed or adjusted in order to perform certain functions or services. Any individual who does not have a facial covering will be provided one.

• **Social Distancing.** All individuals, including invitees, are required to maintain a minimum of six feet (6 ft.) distance between themselves – all individuals must practice “social distancing”.

• **Waiting.** No individuals will be permitted to wait and/or linger in the common areas of Franklin County District Board of Health property.

• **Sickness.** If you have recently felt ill, sick, unwell; live with someone who has recently felt ill, sick, or unwell; or have been around someone that has recently felt ill, sick, or unwell, please do not enter Franklin County District Board of Health property.
- **Fever Check.** By signing below and initialing here I agree to be subject to a temperature check upon entry to the Franklin County District Board of Health property.

## RELEASE AND WAIVER OF LIABILITY

In consideration of Franklin County District Board of Health’s agreement to provide governmental services or provide activities, I, the undersigned, hereby agree for myself, my heirs, executors, administrators, personal representatives, and assigns, to release, acquit, discharge, promise not to sue, indemnify, and hold harmless Franklin County District Board of Health, its officers, agents, independent contractors, and/or employees from any and all liabilities, losses, claims, damages, demands, actions or proceedings which may arise out my election to seek and obtain the services of Franklin County District Board of Health, its officers, agents, independent contractors, and/or employees. Consistent with the terms of this Notice, Release, and Waiver, I further acknowledge that I assume all risks of harm, injury, illness and damage associated with my permission to obtain services or participate in activities with Franklin County District Board of Health.

I further acknowledge, in light of the current COVID-19 pandemic, that all health and safety efforts undertaken by Franklin County District Board of Health cannot guarantee and entirely prevent, to an absolute certainty, that the COVID-19 virus will not be present within the premises of the Franklin County District Board of Health property. I acknowledge that Franklin County District Board of Health, its officers, agents, independent contractors, and/or employees have taken all proper steps and used their best efforts to prevent the occurrence and/or spread of COVID-19 within its premises.

Based upon the understanding stated above, I do hereby agree for myself, my heirs, executors, administrators, personal representatives, and assigns, to release, acquit, discharge, promise not to sue, indemnify, and hold harmless Franklin County District Board of Health, its officers, agents, independent contractors, and/or employees for any illness, injury, sickness, disease, infection, or death stemming from COVID-19.

I HAVE READ THE ABOVE AND VOLUNTARILY AGREE TO THE TERMS SET FORTH:

<table>
<thead>
<tr>
<th>Signature:</th>
<th>Date:</th>
</tr>
</thead>
</table>

Relationship to Client:

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

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

<table>
<thead>
<tr>
<th>V / P / A</th>
<th># Fee Lot #</th>
<th># Fee Lot #</th>
<th># Fee Lot #</th>
</tr>
</thead>
<tbody>
<tr>
<td>HepB ped</td>
<td>Quadracel</td>
<td>Td</td>
<td></td>
</tr>
<tr>
<td>Pentacel</td>
<td>ProQuad</td>
<td>HepA-Adult</td>
<td></td>
</tr>
<tr>
<td>Pediarix</td>
<td>Polio</td>
<td>HepB-Adult</td>
<td></td>
</tr>
<tr>
<td>Prevnar 13</td>
<td>Tdap</td>
<td>Twinrix</td>
<td></td>
</tr>
<tr>
<td>RotaTeq</td>
<td>Gardasil</td>
<td>Pneumo 23</td>
<td></td>
</tr>
<tr>
<td>DTaP</td>
<td>Menactra</td>
<td>Shingles</td>
<td></td>
</tr>
<tr>
<td>Hib</td>
<td>Bexxero</td>
<td>Flu-High</td>
<td></td>
</tr>
<tr>
<td>MMR</td>
<td>Flu-0.5ml</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td>□ Client advised to stay □ Will Call □ MOGE:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HepA-ped</td>
<td>Due:_______</td>
<td>Appt:_______</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Needs:_______</td>
<td>Clinic:______</td>
<td></td>
</tr>
</tbody>
</table>

Vaccine Administrator: Date:

Total Charge Ticket Fee = $

PPE V.A.: face shield goggles safety glasses surgical mask n95 gloves gown

PPE client/family: cloth mask surgical mask under 2y.o. no mask

Notes:

5269812:1