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 □ in NextGen □ Historicals in
	□ Canal □Clinton □ Dublin □ FCPH □ Gahanna □ Grove City
	□ Norwich □ Prairie □ Reynoldsburg □ Westerville □ Whitehall

Person receiving vaccine

Last Name	First Name	M.I.
Birth Date (MM/DD/YYYY)	Age	Gender □ Male □ Female
Street Address	City	State / Zip
Race (check all that apply): □ Asian □ Black/African American □ White □ Native American or Alaskan Native □ Other:_____		
Preferred Language □ English □ Spanish □Chinese □ Other:_____		
Ethnicity: □ Hispanic or Latino □ non-Hispanic or Latino		
Cell Phone *(for text reminders)	Email	
Day phone (if different than cell #)		

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 **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 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:	

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:

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				Quadracel				Td			
Pentacel				ProQuad				HepA-Adult			
Pediarix				Polio				HepB-Adult			
Prevnar 13				Tdap				Twinrix			
RotaTeq				Gardasil				Pneumo 23			
DTaP				Menactra				Shingles			
Hib				Bexsero				Flu-High			
MMR				Flu- 0.5ml							
Varicella											
HepA-ped											

□ **Client advised to stay** □ **Will Call** □**MOGE:**

Due:_____ □ **Appt:**_____

Needs:_____ **Clinic:**_____

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:

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