Client Registration/Consent Form
Immunization Program

Date: □ ID Check □ in eCW □ Historicals in
□ Canal □ Clinton □ Dublin □ FCPH □ Gahanna □ Grove City
□ Norwich □ Prairie □ Reynoldsburg □ Westerville □ Whitehall

Office Use Only

Person Receiving Vaccination

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. Are you feeling sick today?      YES  NO

2. Do you have allergies to any medications, food, latex or vaccines?   YES  NO

3. Have you ever had any serious reactions after receiving vaccines in the past?   YES  NO

4. Have you ever had a seizure, or brain or other nervous system problem?   YES  NO

5. Do you have cancer, leukemia, AIDS, or any other immune system problems?   YES  NO

6. In the past 3 months, have you 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. Have you received a transfusion of blood or blood products, or been given immune (gamma) globulin in the past year?   YES  NO

8. Are you pregnant or is there a chance of you becoming pregnant in the next month?   YES  NO

9. Have you received any vaccinations in the last month?   YES  NO

10. Will you be getting a TB test in the next month?   YES  NO

11. For Clients under 8 months old: Have you ever had intussusception (a rare type of intestinal blockage)?   Not Applicable □ YES □ NO

*Normal data rates may apply

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Doctor Information

Do you have a Doctor?  □ No  □ Yes  Primary Care's Location: ________________________________

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 bills 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 and Notice, Release and Waiver of Liability

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.

In consideration of Franklin County Public Health’s provision of services, 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 Public 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 Public 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 Public Health.

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

Signature: ___________________________   Date: ___________________________

Relationship to Client: ___________________________
Patient’s Name: ____________________________

** STOP **  OFFICE USE ONLY

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

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□ 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: