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 eCW ☐ Historicals in
	☐ Canal ☐Clinton ☐ Dublin ☐ FCPH ☐ Gahanna ☐ Grove City
	☐ Norwich ☐ Prairie ☐ Reynoldsburg ☐ Westerville ☐ Whitehall

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)

Question			
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

Rev 06-01-21 *Normal data rates may apply

OVER→

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

V / P / A	#	Fee	Lot #	Exp. Date		#	Fee	Lot #	Exp. Date
HepB ped					Flu- 0.5ml				
Pentacel					Flu-High				
Pediarix					HepA-Adult				
Vaxelis					HepB-Adult				
Prevnar 13					Twinrix				
RotaTeq					Pneumo 23				
DTaP					Shingles				
Hib									
MMR									
Varicella									
HepA-ped									
Quadracel									
ProQuad									
Polio									
Tdap									
Td									
Gardasil									
Menactra									
Bexsero									

□ 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: