Van Wert County Health Department · 1179 Westwood Drive, Suite 300 · Van Wert, OH 45891 · 1-419-238-0808

INFLUENZA VACCINE ADMINISTRATION RECORD-CHILD

Name (Last, First, Middle) PLEASE PRINT	Date of Birth / /	Age	Sex (Circle) Male Female
Street	City, State, Zip Code	Phone	
Insurance: Medicaid or Commercial	Copy of card is needed at time of services rendered.		

1.	Is the person to be vaccinated sick today?	Yes	No
2.	Does the person to be vaccinated have an allergy to latex or to a component of the influenza vaccine (eggs. neomycin, thimerosal, gelatin)?	Yes	No
3.	Has the person to be vaccinated ever had a serious reaction to intranasal influenza vaccine (FluMist) in the past?	Yes	No
4.	Is the person to be vaccinated younger than age 2 years or older than age 18?	Yes	No
5.	Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g. diabetes), or anemia or another blood disorder?	Yes	No
6.	If the person to be vaccinated is a child age 2 through 4 years, in the past 12 months, has a health-care provider ever told you that your child has wheezing or asthma?	Yes	No
7.	Does the person to be vaccinated have cancer, leukemia, HIV/AIDS, or any other Immune system problem; or in the past 3 months, have they taken medications that weaken the immune system, such as cortisone, prednisone, other steroids, or anticancer drugs; or have they had radiation treatments?	Yes	No
8.	Is the person to be vaccinated receiving antiviral medications?	Yes	No
9.	Is the child or teen to be vaccinated receiving aspirin therapy or aspirin-containing therapy?	Yes	No
10.	Is the person to be vaccinated pregnant or could she become pregnant within the next month?	Yes	No
11.	Has the person to be vaccinated ever had Guillain-Barre syndrome?	Yes	No
12.	Does the person to be vaccinated live or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)?	Yes	No
13.	Has the person to be vaccinated received any other vaccinations in the past 4 weeks?	Yes	No

*I have received a copy of the influenza information sheet. I understand the risks and benefits of the influenza vaccine and I request that the influenza vaccine be given to me.

Signature: _____ Date: _____

REVISED 09/18/14

This consent is required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to let you know your rights to privacy with respect to your health care information.

- I give my consent to the Van Wert County Health Department (VWCHD) to use and disclose my protected health information for the purposes of treatment, payment and operations of my health care and this clinic.

- I grant permission for the Van Wert County Health Department to immunize my child in my absence when my child is brought to the clinic by my designee (i.e., grandparent, babysitter, etc.).

- I grant permission to the Van Wert County Health Department to immunize my adolescent/teen less than 18 years of age if he/she comes to the clinic for immunizations unaccompanied by a parent or legal guardian. I understand another appointment will be made in lieu of giving vaccines if a problem arises or if immunizations are in question and I cannot be reached.

- I understand that my child's immunization record will be entered into the Ohio Immunization Registry (IMPACT SIIS) unless I sign a form for removal. I also understand that other entities such as but not limited to: Parent or Guardian, WIC, Physician, Other Health Departments, Dept. of Job and Family Services, School or Preschool, Head Start or Daycare, Hospital, and Ohio Department of Health might be contacted for information or records may be released when deemed necessary.

Consent for release of information for payment and operations: I authorize VWCHD to give information to the identified insurance carriers(s) for any and all payment activities.
A copy of the Privacy statement is hanging up in the waiting room and a copy can be given if asked for by the client.
Consent related to privacy Notice: I have had a chance to review the Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may get these changed notices by contacting VWCHD by phone or in writing. I understand I have the right to ask how my protected health information will be used and/or given out.

- **Signature for HIPAA Consent**: _____ **Date**: _____

Consent for assignment of benefits: I give consent for my insurance to be billed for services received today at the Van Wert County Health Department. I understand that I am responsible for all co-payments, amounts applied to deductibles, and other amounts that may be stated to be my responsibility by the insurance agency, as required by any contract with my insurance agency and state regulation. I also understand that my contract with my insurance agency may or may not cover some services. It is my responsibility to get information from my health insurance agency about services that are covered. If I get care outside of my health insurance plan, I am aware that I may be responsible for all charges that may be due. A returned check fee of $25.00 will be charged to you for a check returned for insufficient funds, stopped payment or closed account.

Signature: _____ **Date:** _____

My insurance is not in-network or it is a non-covered service(s). I will ***self-pay*** for all services & fees.

Signature: _____ **Date:** _____

OR:
I do not have insurance coverage for my child_____

Signature: _____ **Date:** _____