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
	□ Canal □ Dublin □ FCPH □ Jackson □ Norwich	
	□ Prairie □ Reynoldsburg □ Westerville □ Whitehall	

Person receiving vaccine

First Name:	MI:	Last Name:		
Address:	City:		State:	Zip:
Phone	Email:			
Date of Birth (MM/DD/YYYY):	Age:	Gender: □ Male □ Female		

Primary Language: □ English □ Spanish □Chinese □ Other:_____
Race (check all that apply): □ White □ Black/African American □ Asian □ Hispanic/Latino □ Native American or Alaskan Native □ Other:_____
Client School District:

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 nerve problem?	YES	NO
5. Had a health problem with asthma, lung disease, heart disease, kidney disease, metabolic disease such as diabetes, or a blood disorder?	YES	NO
6. Have cancer, leukemia, AIDS, or any other immune system problems?	YES	NO
7. Taken cortisone, prednisone, other steroids or anti-cancer drugs, or had radiation treatments in the past 3 months?	YES	NO
8. Received a transfusion of blood or blood products, or been given immune (gamma) globulin in the past year?	YES	NO
9. Pregnant or is there a chance of becoming pregnant in the next month?	YES	NO
10. Received vaccinations in the last month?	YES	NO
11. Will you be getting a TB test in the next month?	YES	NO

OVER→

Payment Information

Do you have Health Insurance? □ **Yes** □ **No**

If yes, name of Insurance_____

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.

Initials_____

If paying cash/check, would you like to apply for discounted services? □ **Yes** □ **No**

Doctor Information

Have a Doctor? □ **Yes** □ **No**

If yes, Name: _____ **Location:** _____

Reason for Visit:

□ **No Doctor**
□ **No insurance**
□ **Doctor does not offer vaccines**
□ **Doctor does not accept my insurance for vaccines, but offers vaccines at their practice**
□ **No appointment available at my Doctor's office**
□ **Doctor out of vaccine**
□ **Convenience**

Medical Message Permission

May we leave a detailed message on your voicemail/email regarding any medical/clinic information?

□ **Yes** □ **No**

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 (HIPPA), 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:	

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

Consent shown/given (if not parent or guardian): □ **Attached** □ **Given via phone**	
Historical Vaccine:	
Official VFC Status: □ **Privately insured- N** □ **Underinsured- Y** □ **Medicaid - Y** □ **Uninsured - Y** □ **AI/AN- Y**	
FCPH Witness:	**Date:**

Rev 1/2015