JEFFERSON COUNTY General Health District

Prevent. Promote. Protect.

Last Name: _____ First Name: _____ Middle: _____

DOB: _____ **Age**: _____ **Gender**: M F Other

Street Address:_____ **City**:_____ **State**: _____ **Zip**: _____

Phone Number: _____ Primary Language: _____ Ethnicity: Hispanic Non-Hispanic

Race: White Asian Black/African American Native American/Alaskan Native Other

Parents or Guardian information for children under the age of 17:

Name(First, Last)	**Relationship:**	**Phone:**
Name (First, Last)	**Relationship:**	**Phone:**

Please answer the following questions below for the person receiving the vaccine:	Y	N	U
1. Are you sick today?			
2. Do you have allergies to medications, food, a vaccine component, or latex?			
3. Have you ever had a serious reaction after receiving a vaccination?			
4. Do you have a long-term health problem with lung disease, heart disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia, or a blood disorder?			
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?			
6. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?			
7. Have you had a seizure or a brain or other nervous system problem?			
8. During the past year have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?			
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?			
10. Have you received any vaccinations in the past 4 weeks?			

ACKNOWLEDGEMENT, AUTHORIZATION and ASSIGNMENT OF BENEFITS

I acknowledge that I have been offered a copy of the Jefferson County General Health District (JCGHD) Notice of Privacy Practices.
A copy of the Vaccine Information Statement(s) has been provided. I have read, or have had explained, the information about the disease(s) and vaccine(s) listed. I had an opportunity to ask questions and believe that I understand the benefits of the vaccine(s). I consent to the administration of the vaccines listed to be given to the person named above and I am authorized to give this consent.
I agree to the electronic transmission of immunizations and other information on this form to the Ohio Department of Health's Immunization Registry.
I give permission for my child's immunization records to be given verbally or in writing to my child's doctor and school if requested.

I authorize JCGHD to release service related information regarding the above mentioned person to third party payers of bill for service(s) rendered to me. I request my payer pay JCGHD directly for services rendered to me.

_____ _____

SIGNATURE OF CLIENT (or, Person Authorized to Sign on the Client's Behalf) **DATE**

NAME OF CLIENT _____ **DOB** _____

VFC eligibility screening for birth-18 years:	
	VFC - Medicaid/Managed Care
	VFC - Uninsured
	VFC- American Indian/Alaskan Native
	VFC- Underinsured at FQHC/RHC/deputized provider
	Not VFC Eligible (Private Insurance)

Vaccine Stock:	
	ODH/317
	VFC
	Private
	Self-pay

Vaccine(s)		Lot Number	Mfr.	VIS Date	Route	Admin Site	Amount
DTaP Under 7 years		Daptacel Infanrix					
DTaP/HepB/IPV ***Pediarix*** Under 7 years							
DTaP/IPV ***Kinrix*** 4 to 6 years							
Gardasil 9 years to 26 years							
HAV *pediatric* 12m to 18 years	**HAV *adult*** 19 years & up	Havrix					
HBV *pediatric* Birth to 19 years	**HBV *adult*** 19 years & up	Engerix-B Recombivax					
Hib (*ActHib)* Under 5 years							
IPV 6wks and up							
MMR 12m and up	**MMRV** 4 to 12 years						
MCV-4 11 years to 55 years		Menactra Menveo					
MenB/Trumenba 16 years to 23 years							
PCV13 / Prevnar13 2m to 4 years Adults 65 and up							
PPSV23							
Tdap 7 years and up	**Td**	Boostrix Adacel					
Rotavirus Up to 8months, 0 day							
Varicella (chickenpox) 12m and up							

Signature **Title** **Date:** **Time**