



**AUGLAIZE COUNTY**  
HEALTH DEPARTMENT

*prevent. promote. protect.*

**\* Please complete both sides of form \***

**Adult (19+ older) RSV  
Vaccine Administration Form**

Date: / / Age /

Name: Last, First, MI		Client's SS#		Date of Birth	Age
Address		City	State	Zip	County
Phone	Text Msg # (For Appt. Reminders)	Sex	Race	Doctor	

		Yes	No
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 to a vaccine in the past?		
4.	Have you ever received RSV vaccine in the past?		
5.	In the past 3 months, have you taken medications that weaken 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?		

**Please mark all that apply to you:**

		Yes	No
6.	I am pregnant with a gestational age between 32 weeks 0 days and 36 weeks 6 days.		
7.	I am 75 years of age or older.		
8.	I am 60 through 74 years of age and meet criteria for being at risk for RSV.		

**\*\*If you answered YES to question 8, please mark which condition(s) apply to you:**

Chronic cardiovascular disease	
Chronic lung disease	
Chronic liver disease	
Chronic hematologic disorder	
End-stage renal disease	
Severe obesity	
Diabetes mellitus	
Moderately or severely immunocompromised	
Neurologic or neuromuscular conditions	
Residence in a nursing home	

		Yes	No
9.	Does this client have health insurance from an employer or private purchase?		
10.	If yes to question 9, does this insurance pay for immunizations?		
11.	Does this client have Medicaid or insurance through Job & Family Services?		
12.	Does this client have Medicare or Medicare Advantage Plan?		

**Auglaize County Health Department Staff Use Only**

Vaccine declined when recommended: \_\_\_\_\_ Education and information provided:

	Vaccine/VIS	Date Given	Manufacturer	Lot #	Injection Site	Administrator
V	P				LT RT LD RD PO	
V	P				LT RT LD RD PO	
V	P				LT RT LD RD PO	

TOTAL CHARGE: \$ \_\_\_\_\_

INSURANCE INFORMATION \_\_\_\_\_

## Patient Financial Responsibility Form

Father/Guardian		
Name: _____		
Date of Birth: _____		
Address: _____		
City: _____	State: _____	Zip: _____
Phone: _____		

Mother/Guardian		
Name: _____		
Date of Birth: _____		
Address: _____		
City: _____	State: _____	Zip: _____
Phone: _____		

Primary Insurance	
Name of Insurance:	Policy Holder's Name:
Policy Holder's Home Address:	
Relationship to Patient:	Policy Holder's Employer:
Policy Holder's Phone #:	Policy Holder's Date of Birth:

**Is Patient Covered by any additional insurance?                      Yes (\*)                      No**

Secondary Insurance (*)	
Name of Insurance:	Policy Holder's Name:
Policy Holder's Home Address:	
Relationship to Patient:	Policy Holder's Employer:
Policy Holder's Phone #:	Policy Holder's Date of Birth:

- **Authorization to pay benefits to Auglaize County Health Department (ACHD):**  
I authorize payment be made directly to ACHD for medical services provided to me or my family members.
- I authorize the release of any medical or other information necessary to process this claim.
- I understand that I will assume full responsibility for payment for services, if my insurance denies or does not cover my claim for services rendered at ACHD. I accept financial responsibility with or without the use of insurance coverage.
- I understand that I am responsible for notifying the ACHD if there is a change in the insurance coverage or funding status.
- **Deductible:** I understand that if my insurance carrier determines that I have not met my deductible, that I will be fully responsible for payment in a timely manner. Payment will be made within 30 days of notification by my insurance carrier or ACHD
- I understand I am responsible for all charges incurred by not providing the most current, correct insurance information to the ACHD.
- **Sliding Fee Scale Agreement:** If payment for services is determined by and based on a sliding fee scale. I understand that I am responsible for my share of the cost of service rendered.

### IMMUNIZATION CONSENT FORM

\*I acknowledge having a chance to review & keep the Auglaize County Health Department (ACHD) Notice of Privacy Practices. Copies of the Privacy Notice are displayed in the Health Department. I understand the terms of the Privacy Notice may change and I may get these changed notices by contacting ACHD 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.

\*I understand ACHD may disclose my protected health information for the purposes of treatment, payment and operations of my health care and this clinic. **Examples of entities requesting information:**

Parent or Guardian	Help Me Grow	Insurance Carriers	Schools / Preschools	Daycare or Head Start
State of Ohio Immunization Registry	Job & Family Services	Other Health Departments	WIC	

\*I understand an appointment reminder or missed appointment notice may be sent by postcard or letter in the mail, telephone / answering machine or voicemail, or text message.

\* I understand ACHD utilizes the ACIP Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger and the Recommended Adult Immunization Schedule for ages 19 years or older published by the CDC. I understand combination vaccine may be utilized.

\*I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after vaccination.

\*I hereby give consent to the Auglaize County Health Department staff to administer the requested / determined vaccination(s) to myself or the person named for whom I am authorized to make this request (as Parent/Guardian). I have received a copy of the most up to date Vaccine Information Statement(s) for the vaccine(s) to be given and have had the opportunity to ask questions and have them answered to my satisfaction. I understand the benefits / risks associated with the vaccines to be given.

**SIGN:** Patient/Parent/Legal Guardian Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_

\*\*\*\*\***AUGLAIZE COUNTY HEALTH DEPARTMENT (STAFF USE ONLY)**\*\*\*\*\*

**Possible Risks & Reactions Discussed? Yes No** \_\_\_\_\_ (Signature of Reviewer)