

Name: Last, First, MI		Date of Birth		Age	
Address		City	State	Zip	County
Phone		Sex	Race:		Client SS#
Mother's Name (if minor)		Father's Name (if minor)			

Please answer the following questions to the best of your knowledge:	Yes	No	Don't Know
1. Are you sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have allergies to medications, food, a vaccine component, or latex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a serious reaction after receiving a vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have any of the following: a long term health problem with the heart, lung, kidney, or metabolic disease (ex: diabetes), asthma, a blood disorder, no spleen, a cochlear implant, or spinal fluid leak? Are you on long-term aspirin therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. In the past 6 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you had a seizure or a brain or other nervous system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you has Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes Covid-19?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. In the past year, have you received immune (gamma) globulin, blood/blood products, or an antiviral drug?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you received any vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever felt dizzy or faint before, during, or after a shot?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Are you anxious about getting a shot today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you ever received a dose of COVID-19 vaccine? If yes, please answer the following:			
• Type received (Moderna, Pfizer, Janssen, or Novavax) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• How many doses of Covid vaccine administered _____			
• Date of last dose _____			

IMMUNIZATION CONSENT FORM

I grant permission to the Auglaize Co Health Department to give the requested vaccines to myself or the person named above for whom I am authorized to make this request. I have read or had explained to me the information from the vaccine information statement and understood the risks and benefits of this vaccine. I have received or have been offered the HIPAA Privacy Notice and the Vaccine Information Statements. I understand that the person vaccinated should wait 15 minutes after receiving the vaccine. If the person leaves the vaccination site before 15 minutes have passed, I assume any risks associated with not waiting the recommended amount of time.

Patient/Parent/Legal Guardian Name: _____ Date: _____

Reviewed by Staff/Volunteer Member: _____ Date: _____

Insurance Information: Please complete and have all insurance cards (Primary & Secondary) available at your appointment

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

Select all that apply:

- I request ACHD to bill my **Commercial Insurance Plan** (provide copy of the card)
- I request ACHD to bill my **Medicare or Medicare Advantage Plan** (provide copy of the primary card)
- I request ACHD to bill my **Medicaid Plan** (provide copy of the card)
- I have no insurance
- My insurance doesn't cover the cost of this vaccine (please verify prior to appt.)

- **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. I understand I am responsible for all charges incurred by not providing the most current, correct insurance information to the ACHD.
- **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
- **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.

Patient/Parent/Legal Guardian Consent /Signature:

X _____ **Date:** _____

STAFF USE BELOW

	Vaccine/VIS	Date Given	Manufacture	Lot#	Injection Site	Administrator
P	COVID (12+formula)		Pfizer		LT RT LD RD	
V	COVID (12+formula)		Pfizer		LT RT LD RD	