Van Wert County Health Department

1179 Westwood Dr., Ste. 300 Van Wert, OH 45891 (419)238-0808

INFLUENZA VACCINE ADMINISTRATION RECORD-CHILD

Name (Last, First, Middle) PLEASE PRINT	Date of Birth	Age	Sex (Circle)
Accompanying Adult's Name	/ /		M F

Street	City, State, Zip Code	Phone

Name of Insurance: _____ Name of Policy Holder: _____

Birthdate of Policy Holder: _____/_____/_____ Insurance ID#_____

Employer Name of Policy Holder:_____Group #_____

SSN of Policy Holder: _____-_____-_____

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 being vaccinated ever have a serious reaction to influenza vaccines in the past? Yes No
4. Has the person to be vaccinated ever had Guillain-Barre syndrome? 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: _____

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 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**: _____

********** Please complete the back of this form**********

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:** _____

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

Lot Number **Mfg** **Exp. Date** **CLINIC SITE 71 OR OTHER_____**	**Date and Initials of Vaccinator** LNB LSB NG TM **Date: / /** **LD RD LT RT**