

MR # : _____

Patient Name: _____ **Birth 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 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:** _____

Screening Checklist for Contraindications to Vaccines for Children and Teens:

For Parents/Guardians: The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, ask your healthcare provider to explain it. Circle those that apply.

1.) Is your child sick today?	YES	NO	N/A
2.) Does the child have allergies to medications, food, a vaccine component, or latex?	YES	NO	N/A
List if applicable:			
3.) Has the child had a serious reaction to a vaccine in the past?	YES	NO	N/A
4.) Does the child have a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Is he/she on long-term aspirin therapy?	YES	NO	N/A
List if applicable:			
5.) If the child to be vaccinated is between ages of 2 and 4 years, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	YES	NO	N/A
6.) If your child is a baby, have you ever been told he or she has had intussusception?	YES	NO	N/A
7.) Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	YES	NO	N/A
8.) Does the child or family member have cancer, leukemia, HIV/AIDS, or any other immune system problem?	YES	NO	N/A
9.) In the past 3 months, has the child taken medications that affect the immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	YES	NO	N/A
10.) In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	YES	NO	N/A
11.) Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	YES	NO	N/A
12.) Has the child received vaccinations in the past 4 weeks?	YES	NO	N/A

Form completed by: _____ **Date:** _____ **Form Reviewed by:** _____ **Date:** _____

Future Visits Reviewed and Initialed by **Parent/Guardian:**

Initial ____ & date ____ Initial ____ & date ____ Initial ____ & date ____ Initial ____ & date ____ Initial ____ & date ____

Future Visits Reviewed and Initialed by **Nurse:**

Initial ____ & date ____ Initial ____ & date ____ Initial ____ & date ____ Initial ____ & date ____ Initial ____ & date ____