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Van Wert County General Health District - CHILD (0-18 yrs.)

1179 Westwood Drive, Suite 300, Van Wert, OH 45891 (419) 238-0808

	ı			PATIENT	INFORM	IATION:					
Legal Name:	Last			First					Middle		
Birth Date:	1	/	/	Social Sec	l Security#:			Race:	Race:		
Mailing Addre	ess:							Apt./Lot #			
City:					State:			Zip:			
Primary Phone	e #:					Secondary	Phone #:				
Sex: M	Е	Primary C	are Physicia	n:		occomuta. y					
Mother/Guard	<u>, </u>		are i nysiciai				Phone #:				
Email:	aran realine	•					r none m				
Father/Guardi	ian Name						Phone #:				
Email:	idir radiries						r none m				
Emergency Co	ntact:			Relationsh	in·		Phone #:				
Lineigency co	illact.		l		•	MATION:					
Person Respoi	nsible for F	Pavment:				-					
Primary Insura						Primary Ca	rd Holder:				
Birth Date (Po		r):				Employer N					
Insurance ID#						Group #:					
Secondary Ins						Secondary	Card Holde	er:			
Birth Date (Po		r)				Employer N					
·	-	<u>, </u>									
Insurance ID#: Consent for assignm am responsible for by any contract wit my responsibility to may be responsible closed account.	nent of benefi all co-paymen h my insuranc o get informati	ts, amounts a e agency and on from my l	applied to deduct I state regulation health insurance	ables, and othe I also understa agency about so	er amounts that and that my cor ervices that are	may be stated to stract with my in covered. If I ge	o be my respon surance agenc t care outside o	nsibility by the ir y may or may no of my health insu	nsurance age ot cover some rance plan, I	ncy, as required e services. It is am aware that I	
							Dete				
Signature:				· ·			Date:				
Future Visits Re	viewed and	initialed p	y <u>Parent/Guai</u>	raian:							
Initial&da	te	Initial	&date	Initia	l&date_	Ini	tial&da	te	Initial	_&date	

	MF	K # :				
Patient Name: Birth D	Birth Date:					
This consent is required by the Health Insurance Portability and Accountability Act (HIPAA)	of 1996 to	o let you kr	now your			
rights to privacy with respect to your health care information.		·	•			
If I give my consent to the Van Wert County Health Department (VWCHD) to use and disclose my protected health information for operations of my care and this clinic. If I understand that my child's immunization record will be entered into the Ohio Immunization Registry (IMPACT SIIS) unless I sign other entities such as but not limited to: Parent or Guardian, WIC, Physician, Other Health Departments, Dept. of Job and Family Support of Parent or Guardian, WIC, Physician, Other Health Departments, Dept. of Job and Family Support of Parent or Guardian, WIC, Physician, Other Health Departments, Dept. of Job and Family Support of Parent or Guardian, WIC, Physician, Other Health Departments, Dept. of Job and Family Support of Parent Other Health Might be contacted for information or records may be released when deemed	n a form for r Services, Scho	emoval. Talso u	understand that			
Consent for release of information for payment and operations: I authorize VWCHD to give information to the identified insurar 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 understacthange and I may get these changed notices by contacting VWCHD by phone or in writing. I understand I have the right to ask how used and/or given out.	and that the t	erms of the Priv	vacy Notice may			
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 toda does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If nealthcare provider to explain it. Circle those that apply.	a question		sk your			
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 ne/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 nad wheezing or asthma in the past 12 months?	YES	NO	N/A			
5.) 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			
3.) Does the child or family member have cancer, leukemia, HIV/AIDS, or any other immune system problem?	YES	NO	N/A			
2.) 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			
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Form completed by: Date: Form Reviewed by:		Dat	te:			
Future Visits Reviewed and Initialed by <u>Parent/Guardian</u> : Initial&date	e	Initial	_&date			
Future Visits Reviewed and Initialed by <u>Nurse</u> : Initial&date	e	Initial	_&date			