MERCER COUNTY CELINA CITY Health Department
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IMMUNIZATION SCREENING FORM

Patient Name: _____ _____ _____ _____
Last Name First Name M.I. Birthdate male or female

_____ _____ _____ _____
Address City State Zip

Phone: Insurance Carrier:

Please answer the following questions:	Yes	No	UNSURE
1. Is the person to be vaccinated sick today?			
2. Are there any allergies to medications, food, vaccines or latex?			
3. Has there ever been a serious reaction after receiving a vaccination?			
4. Is there a health problem; heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, blood disorder, or are you taking blood thinners or daily aspirin?			
5. Is there any cancer, leukemia, AIDS, or any other immune system problem?			
6. Has there been cortisone, prednisone, steroids, anticancer drugs, or any radiation treatments in the past 3 months?			
7. Has there been a seizure, brain, or other nervous system problem in any immediate family member? (patient, parent or sibling)			
8. If the child to be vaccinated is between the ages of 2 and 4 years, has a Healthcare provider told you that the child had wheezing or Asthma in the past 12 months?			
9. If your child is a baby, have you ever been told he or she has had intussusception?			
10 Has there been a blood transfusion, blood products, immune (gamma) globulin or antiviral given in the past year?			
11. For females: Is there any chance of pregnancy now or during the next month?			
12. Has the patient received vaccinations in the past 4 weeks?			

I have been provided the Vaccine Information Sheets for the vaccines received today and had the opportunity to receive the Notice of Privacy Practice for the MCCCHD.

X (Patient/Parent/Guardian) – PRINT NAME – _____

X (Patient/Parent/Guardian) - SIGN NAME – _____

*MCCCHD office use Only * MCCCHD office use Only * MCCCHD office use Only * MCCCHD office use Only*

	Yes	No
Patient appears within normal limits.		
Patient/parent/Guardian denies concerns.		
Form reviewed by nurse and all concerns addressed.		
Notes:		

Nurse Signature: _____ *Date:* _____

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Insurance Form

Insurance Responsible Party Name: _____ _____ _____ _____ _____
Last Name First Name M.I Birthdate Age

Address: _____ City: _____

State: _____ Zip: _____ SS#: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Employer Name: _____ Work Phone: (_____) _____

Please list all other dependents covered under this insurance provider: **Relationship to Insured**

Name: _____ D.O.B _____ Male ____ Female ____ _____

Name: _____ D.O.B _____ Male ____ Female ____ _____

Name: _____ D.O.B _____ Male ____ Female ____ _____

Name: _____ D.O.B _____ Male ____ Female ____ _____

***** please check here if client's address is different from insured** ☐

Mother's Full Name/Guardian (please print): _____

Father's Full Name/Guardian (please print): _____

If the client is a minor, who has **legal** custody? Both Parents □ Mother □ Father □ Guardian □

Check all that applies:

- □ Medicaid/Healthy Start Health Insurance
- □ Health Insurance: Does your health insurance cover vaccines? □ Yes □ No
- □ No Health Insurance
- □ American Indian or Alaskan Native
- □ Medicare

Primary Insurance
Insurance Name: _____

Policyholder Name: _____

ID#: _____

Group#: _____

Secondary Insurance
Insurance Name: _____

Policyholder Name: _____

Date of Birth: _____

ID#: _____

Group#: _____

Employer: _____

Please complete both sides of form

220 W Livingston St - B 152, Celina, Ohio 45822
Phone 419-586-3251- Fax 419-586-2583- e-mail healthdept@mccchd.org
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Client Financial Responsibility Form

- **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 the Mercer County Celina City Health Department (MCCCHD). I accept financial responsibility with or without the use of insurance coverage.**

  o Please Initial _____

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

  o Please Initial _____

- **Deductible:** I understand that if my insurance carrier determines that the claim for services rendered will go towards my deductible, I will be fully responsible for payment in a timely manner. Payment will be made within 30 days of notification by the MCCCHD.

  o Please Initial _____

- I understand that I am responsible for notifying the MCCCHD if there is a change in the insurance coverage or funding status.

  o Please Initial _____

- I authorize payment for services provided to be paid directly to the MCCCHD.

  o Please Initial _____

- The MCCCHD will bill your insurance carrier if you provide all necessary information. A $15.00 fee will be charged for all returned checks.

X **PRINT** Patient/Parent/Legal Guardian Name: _____

X **SIGN** Patient/Parent/Legal Guardian Name: _____

Relationship to Patient: _____

MCCCHD Signature: _____ Date: _____

S:/Nursing Folder/Forms 4-2015

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Health Services Consent Form
Client Information

Last Name	First Name	MI	Birthdate	Gender M or F

I acknowledge that I have been given the opportunity to review and keep the Mercer County Celina City Health Department (MCCCHD) Notice of Privacy Practice. I understand that the terms of the Notice of Privacy Practice (NPP) may change. I can obtain an updated NPP by contacting the MCCCHD by phone or writing. The NPP is posted in the Health Services waiting room and on the website, www.mcchd.org.

I understand the MCCCHD may disclose my protected health information (PHI) for the purposes of treatment, payment, and operations. Examples of entities requesting information:

Parent, Guardian, Power of Attorney, Job and Family Services
Day Care, Head Start, Preschools, Schools,
Other Health Departments, Physician offices, Hospitals
Help Me Grow, Women Infant and Children(WIC),
Information is uploaded to Ohio Immunization Information System(IMPACT),
Private Insurance Carriers, Medicaid, Medicare, and Third Party Electronic Biller.

I understand an appointment reminder or recall may be sent by mail/telephone/answering machine/email or text.

I grant permission for the MCCCHD to immunize my child in my absence when brought to the clinic by my designee. I understand that I will need to complete the screening, insurance, and patient financial responsibility form and have the designee bring the forms and insurance cards at the time of the appointment. The MCCCHD clinic staff may call parent/guardian for teaching and information before providing services. This permission will be required for any child under the age of 18 years. Anyone under the age of 18 is advised to have a designee present at the time of service.

I or my designee will be given the vaccine information sheets for each vaccine given or recommended and will be given the opportunity to address any concerns. I understand the benefits/risks associated with the vaccines to be given. I am aware of the Vaccine Adverse Event Reporting System (VAERS).

The MCCCHD follows the guidelines and standing orders under the direction of the Advisory Committee on Immunization Practices (ACIP) and the MCCCHD Medical Director. There are circumstances when the ACIP makes recommendations to reduce the burden of disease that are not approved by the Food and Drug Administration. This is called Off Label. You will be notified if you are reciving an off-label vaccine.
For more information please go to www.immunize.org.

Patient/Parent/Guardian Signature Date

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