Athens City-County Health Department
happy. healthy. prosperous.

IMMUNIZATION & TB CONSENT FORM

Athens City-County Health Department
278 West Union Street
Athens, Ohio 45701

Last Name	**First Name**	**Middle Name**	
Date of Birth	**Age**	**Gender** Male Female	
Street Address	**City** **State** **Zip**		**Phone #**
Primary Language ☐ English ☐ Other_____	**Ethnicity** ☐ Hispanic ☐ Non-Hispanic	**Country of Birth**	
Race ☐ White ☐ Asian ☐ Black/African American ☐ Native American/Alaskan Native ☐ Other			

Please answer the following questions below for the person receiving the vaccine:	Y	N	U
1. Are you sick today?			
2. Do you have allergies to medications, food, a vaccine component, or latex?			
3. Have you ever had a serious reaction after receiving a vaccination?			
4. Do you have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g. diabetes), asthma, a blood disorder, no spleen, complement disorder, component deficiency, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?			
5. Do you or a close family member have cancer, leukemia, HIV/AIDS, or any other immune system problem?			
6. In the past 3 months, have you taken medications that affect your immune system, such as , prednisone, cortisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?			
7. Have you had a seizure or a brain or other nervous system problem?			
8. During the past year have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?			
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?			
10. Have you received any vaccinations in the past 4 weeks?			

ACKNOWLEDGEMENT, AUTHORIZATION & ASSIGNMENT OF BENEFITS

I acknowledge that I have been offered a copy of the Athens City-County Health Department's (ACCHD) Notice of Privacy Practices.
A copy of the Vaccine Information Statement(s) has been provided. I have read, or have had explained, the information about the disease(s) and vaccine(s) listed. I had an opportunity to ask questions and believe that I understand the benefits of the vaccine(s). I consent to the administration of the vaccines listed to be given to the person named above and I am authorized to give this consent.
I agree to the electronic transmission of immunizations and other information on this form to the Ohio Department of Health's Immunization Registry.
I give permission for my child's immunization records to be given verbally or in writing to my child's doctor and school if requested.

I authorize ACCHD to release service related information regarding the above mentioned person to third party payers of bill for service(s) rendered to me. I request my payer pay ACCHD directly for services rendered to me.

_____ _____

SIGNATURE OF CLIENT or Person Authorized to Sign on the Client's Behalf **DATE**

NAME OF CLIENT_____ **DOB** _____

VFC eligibility screening for birth-18 years:	
	VFC - Medicaid/Managed Care
	VFC - Uninsured
	VFC- American Indian/Alaskan Native
	VFC- Underinsured at FQHC/RHC/deputized provider
	Not VFC Eligible (Private Insurance)

Vaccine Stock:	
	ODH/317
	VFC
	Private
	Self-pay

Vaccine(s)	Lot Number	Mfr.	VIS Date	Route	Admin Site	Amount
DTaP Under 7 years 90700	Daptacel Infanrix			IM		
DTaP/HepB/IPV ***Pediarix*** Under 7 years 90723						
DTaP/IPV ***Kinrix*** 4 to 6 years 90696						
Gardasil 9 years to 26 years 90651				IM		
HAV *pediatric* 12m to 18 years 90633 **HAV *adult*** 19 years & up 90632	Havrix Vaqta			IM		
HBV *pediatric* Birth to 19 years 90744 **HBV *adult*** 19 years & up 90746	Engerix-B Recombivax			IM		
Hib (*ActHib)* Under 5 years 90648				IM		
IPV 6wks and up 90713				SQ		
MMR 12m and up 90707 **MMRV** 4 to 12 years 90710				SQ		
MCV-4 11 years to 55 years 90734	Menactra Menveo			IM		
MenB/Trumenba 16 years to 23 years 90621				IM		
PCV13 / Prevnar13 2m to 4 years Adults 65 and up 90670				IM		
PPSV23 90732				IM		
Tdap 7 years and up 90715 **Td** 90714	Boostrix Adacel			IM		
Rotavirus Up to 8months, 0 day 90680				PO		
Varicella (chickenpox) 12m and up 90716				SQ		
TB Skin test **Reason:**				ID		

_____**RN** _____ _____

Signature **Title** **Date** **Time**

Nursing Assessment/Teaching/Vaccine Administration