Toledo-Lucas County Health Department – SHOTS 4 TOTS n Teens
CONSENT TO IMMUNIZE

Name (patient):_____ / _____
(First Name) (Middle Initial)

_____
(Last Name)

Date of Birth (patient): _____ / _____ / _____
(Month) (Date) (Year)

Name (parent/guardian):_____ / _____
(First Name) (Middle Initial)

_____
(Last Name)

Date of Birth (parent/guardian): _____ / _____ / _____
(Month) (Date) (Year)

Address (parent/guardian):_____

_____
(City) (State) (Zip Code)

I AUTHORIZE the Toledo-Lucas County Health Department to provide immunizations to my child as determined by the nurse. The person named below has my permission to bring my child for shots. A photo I.D. may be requested.

Name of Person Representing Parent or Guardian:_____

Phone Number where Parent can be reached: _____

_____ _____
Parent/Guardian Signature Date

Toledo-Lucas County Health Department
CHILDHOOD IMMUNIZATION RECORD & CONSENT FORM

PATIENT INFORMATION:

CHILD'S LEGAL NAME (FIRST) _____ IN**ITIAL**_____(**LAST**)_____

CHILD'S DATE OF BIRTH_____ **CHILD'S SOCIAL SECURITY #** _____

GENDER _____ MALE _____FEMALE **RACE/ETHNICITY** _____**LANGUAGE**_____

PARENT or GUARDIAN'S NAME_____ **SS #** _____

DATE OF BIRTH _____ **PHONE #**_____

ADDRESS_____**CITY**_____**STATE**_____**ZIP CODE**_____

E-MAIL ADDRESS_____**CELL PHONE # FOR TEXT REMINDERS**_____

INSURANCE INFORMATION:

Name of *Primary* Insurance:_____

Group Name: _____ **Group #:**_____ **ID #:**_____

(OR) Medicaid Billing ID Number (MMIS#):_____ or A #:_____

Name of *Secondary* Insurance:_____

Group Name: _____ **Group #:**_____ **ID #:**_____

(OR) Medicaid Billing ID Number (MMIS#):_____or A #:_____

Who carries the insurance on this child (which parent or guardian)? *Complete only if someone other than person named above.*

NAME: (FIRST) _____ (**INITIAL**) ____(**LAST**)_____

ADDRESS (if other than parent above)**:**_____

CITY _____**STATE** _____ **ZIP CODE**_____

INSURED'S SS # (if other than parent above)**:**_____ **INSURED'S DATE OF BIRTH** _____

INSURED'S EMPLOYER: _____

VACCINE FOR CHILDREN PROGRAM ELIGIBILITY

Children who qualify (see below) are eligible for free vaccine through the Vaccine For Children (VFC) Program of the US Government. The
Health Department offers a supply of vaccine for those who do not qualify for the VFC Program. We will bill the patient's private insurance and the responsible party must accept payment responsibility for any co-pays and deductible balances.

Please Check if Any of the Following are TRUE:

_____ My child does not have ANY insurance.
_____ My child is a Native American or Alaskan Native.
_____ My child has health insurance that does not cover ANY vaccines.
_____ My child is enrolled in a Medicaid Insurance Program.

Do you receive WIC?
_____ yes
_____ no

I authorize the vaccines and/or treatment considered necessary for the above-named child by the Toledo-Lucas County Health Department personnel. I understand that my child's vaccine record will be kept on the Immunization Registry of the Ohio Department of Health and authorize release of said information. I authorize billing my insurance for services received, including Medicaid participants. **.** I have received information regarding the Health Information Portability Act. **I accept full financial responsibility including co-pays, balances for unmet deductibles, and any other charges related to Shots 4 Tots services. I verify the above information to be true and correct to my knowledge.**

_____ *(Please Initial)* **I authorize the release of medical or other information necessary to process this claim.**
_____ *(Please Initial)* **I authorize payment of benefits to the undersigned physician or supplier of services on this claim.**

PARENT / GUARDIAN'S SIGNATURE_____DATE_____

For office use only (circle one): **Bill insurance** **Paid cash or check**

IAP 02/2017

PLEASE PRINT CLEARLY

Toledo-Lucas County Health Department – Shots 4 Tots n Teens
CHILDHOOD IMMUNIZATION RECORD & CONSENT FORM

Child's Name (as it appears on birth certificate)_____

Child's Date of Birth_____

Has Your Child Received Shots with Us Before? ____*YES* ____ *NO* **Will You Be Returning*?*** ____*YES* ____*NO* ____ *MAYBE*
Does Your Child Have A Current Doctor? _____*YES* _____*NO* _____*NOT AT THIS TIME*
How Did You Hear About Us? _____

SCREENING QUESTIONS FOR HEALTH HISTORY	YES	NO	EXPLAIN
Is your child sick today?			
Does your child have a chronic illness or take medications, including long-term aspirin therapy?			
Does your child have any allergies to medications, food, a vaccine component, or latex?			
Has your child ever had a serious reaction to a vaccine?			
Has your child had a health problem with lung, heart, kidney or metabolic disease (such as diabetes), asthma, or a blood disorder?			
If your child is between 2 and 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?			
If your child is a baby, have you ever been told your child has had intussusception?			
Has your child, a sibling or parent had a seizure; has the child had brain or other nervous system problems?			
Has your child received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin or an antiviral drug in the past year?			
Does your child or anyone in the house have a disease or receive treatments that weaken the immune system, such as cancer, leukemia, HIV/AIDS, or other immune system problem?			
Has your child taken cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments in the past 3 months?			
Has your child received vaccinations in the past 4 weeks?			
For teen girls: Could your daughter be pregnant or become pregnant in the next month?			

I authorize the vaccines and/or treatment considered necessary for the above-named child by the Toledo-Lucas County Health Department personnel. I understand that my child's vaccine record will be kept on the Immunization Registry of the Ohio Department of Health and authorize release of said information. I authorize billing my insurance for services received, including Medicaid or Paramount participants. I have received information regarding the Health Information Portability Act. **I accept full financial responsibility including co-pays, balances for unmet deductibles, and any other charges related to Shots 4 Tots n Teens services. I verify the above information to be true and correct to my knowledge.**

PARENT/GUARDIAN'S SIGNATURE _____DATE_____