Franklin County Public Health
280 East Broad Street
Columbus, Ohio 43215-4562
(614) 525-3160
www.myfcph.org

School Flu Consent /Administration Form
Immunization Program

Office Use Only	Date: ☐ in NextGen
	Location:

Person receiving vaccination

First Name:	MI:	Last Name:		
Address:	City:		State:	Zip:
Phone:	Date of Birth:	Age:	Gender: ☐ Male ☐ Female	

Race (check all that apply): ☐ Asian ☐ Black/African American ☐ White ☐ Native American or Alaskan Native ☐ Other_____

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Parent/ Legal Guardian (if applicable)

First Name:	Last Name:
Relationship to Child:	Phone:

Insurance Information

Please mark insurance status and provide appropriate information (select all that apply):

☐ **Medicaid Insurance that Franklin County Public Health is ABLE TO Bill:**

- ☐ Buckeye
- ☐ CareSource
- ☐ Molina
- ☐ Ohio Medicaid
- ☐ Paramount
- ☐ UnitedHealthcare (UHC) Community

☐ **Private Insurance that Franklin County Public Health is ABLE TO BILL:**

- ☐ Aetna (**except** Open Access Managed Choice)
- ☐ Aetna – Meritain Health
- ☐ All Savers through UHC
- ☐ Anthem BC/BS
- ☐ CareSource Marketplace/Healthcare Exchange plans
- ☐ Cigna
- ☐ Golden Rule through UHC
- ☐ Medical Mutual (**except** OhioHealth HMO)
- ☐ UMR through UHC
- ☐ UnitedHealthcare (UHC) (**except** OSU; OSU Student Resources; Compass)

☐ **Other Insurance not listed above: Your child will NOT be vaccinated by FCPH. Please check with your Insurance for a list of Providers who are within your network to receive vaccines.**

☐ **No Insurance** (Your child will receive Vaccines For Children federally funded vaccine for no charge)

Financial Responsibility Statement- Initial if we are billing your insurance

I agree to promptly pay with settlement in full for the medical services provided to myself and/or minor child at the prevailing rates as bill are presented. I understand that I am financially responsible for all the charges that are not covered by my insurance plan. I authorize FCPH to submit a claim to my insurance carrier and I authorize payment directly to FCPH.

** **Initial here →** ☐

Rev 08/28/19

You must complete the backside of this form TURN OVER→

Person being vaccinated Name:_____ **Date of Birth:**_____

Screening questions for person receiving vaccine

1. Have any allergies? Especially to latex, gelatin, chicken eggs/feathers? ***If YES, please list allergies**_____	☐ **Yes** ☐ **No**
2. Any serious reactions after receiving vaccines in the past? ***If YES, please describe**_____	☐ **Yes** ☐ **No**
4. Ever had Guillain-Barré syndrome?	☐ **Yes** ☐ **No**

Consent for Treatment

To the best of my knowledge, I understand the benefits and/or risks of vaccines. I hereby give consent to Franklin County Public Health (FCPH) staff for the administration of the vaccine to myself or for the individual for whom I am authorized to make said request. I have received a copy of the most up-to-date Vaccine Information Statement (VIS). I understand that I will have the chance to ask questions and have them answered to my satisfaction. I acknowledge that I have been offered and/or received the FCPH Notice of Privacy Practice Summary (HIPAA), which explains policies concerning my personal health information. FCPH is authorized to release vaccination information to schools, day cares, and/or others as necessary or required for treatment of care and billing purposes.

Signature (Parent/Legal Guardian's if <18 y.o.): **Date:**

For Staff Use Only

Medical Screener Signature:_____ **VFC** **Private**

Is the child sick today? ☐ **No** ☐ **Yes** **If yes, describe:**_____

☐ **6 months through 64 years Fluzone- prefilled syringe**

Age _____ ☐ 0.5 ml (90686) ☐ Lot #_____ ☐ IM ☐ Left Thigh ☐ Right Thigh ☐ Left Deltoid ☐ Right Deltoid

☐ **4 years through 64 years Flucelvax- Multi-dose vial**

Age _____ ☐ 0.5 ml (90756) ☐ Lot #_____ ☐ IM ☐ Left Thigh ☐ Right Thigh ☐ Left Deltoid ☐ Right Deltoid

Vaccinator Signature:_____ **Date:**_____