



TAZEWELL COUNTY HEALTH DEPARTMENT GENERAL CONSENT FORM

Last Name: _____ Legal First Name: _____ Middle Initial: _____

Address: _____ City/Zip: _____ Phone: _____

Gender: **Male** **Female** **Other** Date of Birth: ____/____/____ Employer (if paying for services): _____

Insurance Information:

Insurance Name: _____ (Examples: Molina, Medicare, Medicaid, Humana)

Policy or Subscriber ID: _____ Group Number (if any): _____

Policy Holder's Name: _____ Date of Birth: ____/____/____

<p>VFC (Vaccinations for Children): Effective January 1, 2013, Tazewell County Health Department was required by law to administer VFC (state supplied) vaccine to only those children who are eligible. We are subject to random audits by the State of Illinois. Therefore, you will be asked to complete a series of questions identifying your VFC status. Every effort will be made to determine eligibility.</p>	<p>Eligible: You must have either Title XIX (19) Medicaid, be uninsured, be under-insured (NO VACCINE COVERAGE ON YOUR INSURANCE) and receiving VFC vaccine through a Federally Qualified Health Center (FQHC), be an American Indian belonging to a tribe, band or organized group recognized by the Secretary of State, or Eskimo, Aleut, or Alaskan Native.</p>
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AIP (Adult Immunization Program) Eligibility: You must either be uninsured or under-insured (insurance does not cover any vaccines, does not cover vaccine that you need, or does not provide first-dollar coverage for vaccines due to a deductible or co-pay.)

If you declare eligibility to receive VFC vaccine or AIP vaccine and TCHD receives notification from an insurance carrier stating you have been reimbursed for services rendered or requesting further information from us to complete a claim, you will receive a statement for the cost difference between the fee for the VFC vaccine that you have already paid and the cost/administration fee for private pay vaccine that we stock.

Notice of Privacy Policy: (Please Initial)

_____ I acknowledge receipt of Tazewell County Health Department's Notice of Privacy Policy.

Authorization to Release Information/ Continuity of Care /Financial Responsibility: (Please Initial)

_____ I authorize the release of any medical information between my provider and TCHD for continuity of care. I authorize the release of any medical information to the Centers for Medicare and Medicaid Services (CMS), my insurance carrier(s), or other entities necessary to determine insurance benefits or benefits payable for related medical services provided to me by Tazewell County Health Department. I also understand insurance billing is a service provided by TCHD and I am responsible for the entire and/or balance of my bill once my insurance(s) have been billed if there is a balance. Regulations pertaining to Medicare and Medicaid assignment of benefits apply.

_____ I authorize Tazewell County Health Department to release immunization data to my (child's) school district upon request.

Consent to Test/Treat/Provide Services:

I authorize Tazewell County Health Department to provide testing, administer treatment, or provide appropriate services as deemed necessary for the care of the patient named below. I certify that I am the patient, parent or legal guardian of the patient. I have read or have had explained to me information about the vaccines/services to be given today. I have had the opportunity to ask questions that have been answered to my satisfaction. I understand that this record will be maintained by the Tazewell County Health Department and immunizations will also be maintained in a confidential computerized immunization registry, and that I can choose to opt out of the registry by completing an "Opt Out of Registry" form at each immunization visit.

I understand I have the right to revoke this authorization by giving written notice to Tazewell County Health Department. This authorization is in effect for one year from the date below.

Signature: _____ Printed Name of Signee: _____

(Parent or Legal Guardian if Patient is a minor)

Date: _____

Office Use Only: ____ PP ____ VFC ____ AIP

Person receiving vaccine: Last Name _____

First Name _____ Middle Initial: _____ Date of Birth: ____/____/____

- | | YES | NO | ? |
|--|--------------------------|--------------------------|--------------------------|
| 1. Is the patient sick today?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does the patient have allergies to food, drugs, latex, or vaccines?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has the patient has a serious reaction to a vaccine in the past?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has the patient had a health problem with lungs, heart, kidneys, diabetes, asthma, a blood clot disorder, or on long term aspirin therapy?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. If patient is a baby, has he/she had intussuptions?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Has the patient, sibling, or parent had a nervous system disorder or seizures?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Does the patient have cancer, leukemia, HIV/AIDS, or other immune problem?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. In the past 3 months , has the patient taken cortisone, prednisone, steroids, anti-cancer drugs, or had radiation treatments?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. In the past year , has the patient received a blood transfusion, blood products, been given immune globulin, or an anti-viral drug?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Has the patient received vaccinations in the past 4 weeks ?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. FOR FEMALES-is the patient pregnant or will become pregnant in the next month?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

DO NOT WRITE BELOW THIS LINE

Given to patient/parent/guardian: ____VIS ____Imm. Records ____Return Date ____Comfort Care

VACCINE LOT NUMBER _____ PP ____VFC ____AIP

<input type="checkbox"/> Rotavirus	<input type="checkbox"/> PO	<input type="checkbox"/> Dtap	<input type="checkbox"/> RAT <input type="checkbox"/> LAT <input type="checkbox"/> RD <input type="checkbox"/> LD	<input type="checkbox"/> Flu <input type="checkbox"/> Nasal <input type="checkbox"/> High Dose	<input type="checkbox"/> RD <input type="checkbox"/> LD <input type="checkbox"/> RAT <input type="checkbox"/> LAT
<input type="checkbox"/> Pediarix (Dtap/IPV/Hep B)	<input type="checkbox"/> RAT <input type="checkbox"/> LAT <input type="checkbox"/> RD <input type="checkbox"/> LD	<input type="checkbox"/> Polio	<input type="checkbox"/> RAT <input type="checkbox"/> LAT <input type="checkbox"/> RD <input type="checkbox"/> LD	<input type="checkbox"/> Tdap	<input type="checkbox"/> RD <input type="checkbox"/> LD
<input type="checkbox"/> Hib	<input type="checkbox"/> RAT <input type="checkbox"/> LAT <input type="checkbox"/> RD <input type="checkbox"/> LD	<input type="checkbox"/> Kinrix (Dtap/Polio)	<input type="checkbox"/> RD <input type="checkbox"/> LD	<input type="checkbox"/> HPV	<input type="checkbox"/> RD <input type="checkbox"/> LD
<input type="checkbox"/> Hep B	<input type="checkbox"/> RAT <input type="checkbox"/> LAT <input type="checkbox"/> RD <input type="checkbox"/> LD	<input type="checkbox"/> MMR	<input type="checkbox"/> RA-SC <input type="checkbox"/> LA-SC <input type="checkbox"/> RT-SC <input type="checkbox"/> LT-SC	<input type="checkbox"/> Men 4-ACYW <input type="checkbox"/> Men B	<input type="checkbox"/> RD <input type="checkbox"/> LD <input type="checkbox"/> RD <input type="checkbox"/> LD
<input type="checkbox"/> Pneumo 20 <input type="checkbox"/> Pneumo 23	<input type="checkbox"/> RAT <input type="checkbox"/> LAT <input type="checkbox"/> RD <input type="checkbox"/> LD	<input type="checkbox"/> MMRV	<input type="checkbox"/> RA-SC <input type="checkbox"/> LA-SC	<input type="checkbox"/> RSV (60+) <input type="checkbox"/> RSV Antibody (infants)	<input type="checkbox"/> RAT <input type="checkbox"/> LAT <input type="checkbox"/> RD <input type="checkbox"/> LD
<input type="checkbox"/> Hep A	<input type="checkbox"/> RAT <input type="checkbox"/> LAT <input type="checkbox"/> RD <input type="checkbox"/> LD	<input type="checkbox"/> Varicella	<input type="checkbox"/> RA-SC <input type="checkbox"/> LA-SC <input type="checkbox"/> RT-SC <input type="checkbox"/> LT-SC	<input type="checkbox"/> Shingles	<input type="checkbox"/> RD <input type="checkbox"/> LD
<input type="checkbox"/> Moderna COVID-19	<input type="checkbox"/> 6 mo - 11 yrs <input type="checkbox"/> 12 yrs +	<input type="checkbox"/> RAT <input type="checkbox"/> LAT <input type="checkbox"/> RD <input type="checkbox"/> LD			

Administering Nurse Signature _____ Date: _____