MERCER COUNTY HEALTH DISTRICT

COVID-19 VACCINATION SCREENING & CONSENT

Patient Name: _____ _____ _____
Last First M.I.

Birth date: _____ Current Age: _____ Phone: _____ Gender: male female

Mailing Address: _____
Street City State Zip Code

Race:
- ○ Black or African American
- ○ Native American or Alaskan
- ○ White
- ○ Other / Multiracial
- ○ Decline

Ethnicity:
- ○ Hispanic origin
- ○ Non-Hispanic origin

Select all that apply:

___I request Mercer County Health District to bill my insurance/Medicaid/Medicare

___ I have no insurance

Insurance Carrier's
Relationship to patient: _____

Insurance Carrier's
Employer name: _____

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

Address: _____ City: _____

State: _____ Zip: _____ Birth Date: _____ Insurance Name: _____

Medicaid/Medicare/Insurance ID Number: _____ Group Number: _____

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

The person to be vaccinated today is in group 1a or 1b. Please check only **one box** in the selection below in reference to the primary reason you are receiving the COVID-19 vaccine. Age Groups will be determined in demographics.

	Emergency Medical Services		Congregate Care Facility Resident
	Nonhospital Healthcare Clinical Staff		Congregate Care Facility Staff
	Nonhospital Healthcare Administrative Staff		State of Ohio Dept. of Dev. Disabilities Resident
	Nonhospital Healthcare Ancillary Staff		State of Ohio Dept. of Dev. Disabilities Staff
	Congenital Disorders or Early Onset Conditions		Working in K-12 schools

Authorization to pay benefits to Mercer County Health District: I authorize payment for medical services provided directly to the Mercer County Health District.

***** No person will be denied COVID-19 vaccine because of inability to pay.**

***** Vaccine availability will depend on supply and ODH guidelines for current tier eligibility.**

***** The MCHD will bill for administrative costs only.**

Signature of Responsible Party: Self, Parent or Guardian: _____

Date: _____

Turn over for Vaccine Questionnaire!!

220 W Livingston St, B 152, Celina, Ohio 45822 419-586-3251

MERCER COUNTY HEALTH DISTRICT

Print Patient Name:_____ **DOB**:_____

PLEASE ANSWER THE FOLLOWING QUESTIONS FOR COVID-19 VACCINE	YES	NO
1. Is the person to be vaccinated sick today?		
2. Has the person to be vaccinated had a vaccine in the past 14 days or intending to receive in the next 14 days?		
3. Does the person to be vaccinated have a bleeding disorder or is on a blood thinner?		
4. Has the person to be vaccinated ever had a severe allergic reaction? Was epinephrine or EpiPen, or hospital treatment needed?		
5. Does the person have a weakened immune system caused by something such as HIV infection, cancer, or immunosuppressive drugs or therapies?		
6. Is the person to be vaccinated pregnant, considering becoming pregnant, or breastfeeding?		
7. Has the person to be vaccinated ever tested positive for COVID-19? If yes, has the person received passive antibody therapy as treatment for COVID-19?		
8. Has the person received a dose of COVID-19 vaccine in the past? Type_____ Date: _____		

I grant permission to the Mercer County Health District to give the COVID-19 vaccination to myself or the person named above for whom I am authorized to make this request (as Parent or Guardian). I have read or had explained to me the information from the Moderna or Pfizer Fact Sheet for Recipients and Caregivers 12-2020 and understand the risks and benefits of this vaccine. I have received or have been offered the HIPAA Privacy Notice and understand that information will be sent to Ohio's Immunization Information System (IMPACTSIIS). I have read or had explained to me "V-Safe After Vaccination Health Checker Information." I understand that the person vaccinated should wait 15 minutes after receiving the vaccine. If the person leaves the vaccination site before 15 minutes have passed, I assume any risks associated with not waiting the recommended amount of time.

Patient/Parent or Guardian

SIGNATURE: _____ DATE_____

FOR HEALTH DISTRICT USE ONLY (S:drive/2019 COVID Vaccine)

FORM REVIEWED AND VACCINE ADMINISTERED BY _____

DATE: _____ Time:_____

Moderna 0.5ml 100mcg LOT: _____ Best Use Date:_____

Pfizer-BioNTech 0.3ml 30mcg LOT: _____ Best Use Date:_____

IM Site: LD RD LVL RVL