MERCER COUNTY HEALTH DISTRICT

2nd dose return
Date: _____
Time: _____
Screening Complete: _____

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 - Physical appearance:
- o White
- o Black or African American
- o Asian / Pacific Islander
- o Native American or Alaskan
- o Other / Multiracial
- o Decline

Ethnicity - Cultural identification:
- o Non-Hispanic origin
- o 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: (_____) _____

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 received a dose of COVID-19 vaccine in the past? Type_____ Date: _____		
3. Does the person to be vaccinated have a history of a bleeding disorder or heparin-induced thrombocytopenia (HIT) 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. Does the person have a history of myocarditis or pericarditis?		
7. Is the person to be vaccinated pregnant, considering becoming pregnant, or breastfeeding?		
8. Has the person to be vaccinated ever tested positive for COVID-19?		
9. If yes for COVID-19 disease, has the person received passive antibody therapy as treatment for COVID-19?		
10. If yes for COVID-19 disease, has the person to be vaccinated been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?		

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 Pfizer, Moderna or Janssen Fact Sheet for Recipients and Caregivers 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) 8-5-2021

FORM REVIEWED AND VACCINE ADMINISTERED BY _____

DATE: _____ Time:_____

Moderna 0.5ml 100mcg LOT: _____

Pfizer-BioNTech 0.3ml 30mcg LOT: _____

IM Site: LD RD LVL RVL

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