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_____ 1st dose date: _____ 2nd dose 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? (Now recommended for pregnant and breastfeeding women)		
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? (wait 90 days)		
10. If yes for COVID-19 disease, has the person to be vaccinated been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A)? (wait 90 days)		

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) 11-30-2021

FORM REVIEWED AND VACCINE ADMINISTERED BY _____

DATE: _____ Time:_____

Coronavirus Vaccine:_____ Primary Dose: 1 2 3

Booster Dose

IM Site: LD RD LVL RVL

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