MERCER COUNTY
HEALTH DISTRICT

COVID-19 VACCINATION SCREENING AND CONSENT

Patient Name: ____
Last First M.I.

Birth date: ____________________ Current Age: __________ Gender: male female

Mailing Address: ____
Street City

State: __________ Zip:________________ Phone: (______) ____________________

Select all that apply:

___I request Mercer County Health District to bill my insurance
___I will pay cash/check at time of service
___I have no insurance

Insurance Name: ____

Insurance ID Number: ______________________________ Group Number:______________

Insurance Holder's Name: ____
Last Name First Name M.I.

Address: ____

City: ______________State: __________ Zip: ________ Birth Date: ____________________

Home Phone: (__________)__________________ Cell Phone: (__________)__________________

Relationship to patient: ____________________ Employer name: ____________________

Authorization to pay benefits to Mercer County Health Department (MCHD): I authorize payment be made directly to MCHD for medical services provided. I authorize the release of any medical or other information necessary to process this claim. I understand that I will assume full responsibility for payment for services, if my insurance denies, does not cover my claim or does not reimburse MCHD in full for services rendered by MCHD. I accept financial responsibility with or without the use of insurance coverage. I understand that I am responsible for notifying MCHD if there is a change in the insurance coverage or funding status. I understand I am responsible for all charges incurred by not providing the most current, correct insurance information to MCHD.

*** MCHD is able to bill contracted insurance carriers only if all necessary information is provided.**
**** No child 18 years and younger eligible for federal vaccine will be denied vaccine because of inability to pay**.
*****A $15.00 fee will be charged for all returned checks.**

Signature of Responsible Party: Self, Parent/Guardian: ______________________________

Date: ____________________

→ ***TURN OVER FOR VACCINE QUESTIONNAIRE*** →

220 W Livingston St – B152, Celina, OH 45822
Ph: (419)586-3251 - Fax: (419)586-3910 - Email: healthdistrict@mchdohio.org
Website: www.mchdohio.org - An Equal Opportunity Employer

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 of last dose: ____________________		
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. Has the person to be vaccinated ever tested positive for COVID-19 in the past 3 months?		
8. If yes for COVID-19 disease, has the person received passive antibody therapy as treatment for COVID-19? (wait 90 days)		
9. 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 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) 9.14.2023**

FORM REVIEWED AND VACCINE ADMINISTERED BY ____

DATE: _________________ Time:_____________

LOT # P M __________________________

IM Site: LD RD LVL RVL

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