Seneca County General Health District
92 E. Perry St. Tiffin, Ohio 44883
CONSENT FOR SERVICES

By my signature below,

1. I consent to the administration of vaccine(s) by an RN at SCGHD who has determined, based on Center for Disease Control's (CDC) Recommended Immunization Schedule and a current vaccine record provided by the client/guardian.
2. I understand that:
    - I have voluntarily chosen to receive the vaccination and understand that I am obligated to pay for all products and services received, if applicable.
    - I may be responsible for payment after the date of service if the product or service is billed to my medical benefit.
    - I am responsible for all co-pays, amounts to be applied to deductibles and other amounts that may be stated to be my responsibility by the insurance carrier.
    - It is my responsibility to know what services are/are not covered under my health insurance plan.
    - I am of legal age and authorized to execute this consent form or I am the parent/guardian of the minor patient.
    - I will alert SCGHD of any medical conditions which may adversely affect my personal health or effectiveness of the vaccine.
    - I have been counseled about potential side effects after vaccination, when they may occur, and when and where I should seek treatment. I am responsible for following up with my physician at my expense if I experience any side effects.
    - I will alert SCGHD of potential side effects for reporting to Vaccine Adverse Event Reporting System (VAERS) and documenting in my medical record.
    - I may be requested to remain in the area for observation after vaccination(s). If I leave the area without waiting, I acknowledge that I am doing so at my own risk and against the advice of the professional who administered the vaccine(s).
    - I have read, or have had read to me, the Vaccine Information Statement(s) ("VIS") or Emergency Use Authorization ("EUA") provided for the vaccine(s) to be administered. I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccine(s).
    - I have been offered and/or provided a copy of SCGHD's Notice of Privacy Practices in compliance with the Health Insurance Portability and Accountability Act (HIPAA).
    - Vaccination(s) are subject to reporting by SCGHD to the Ohio ImpactSIIS (an immunization registry maintained by the Ohio Department of Health), which may share my immunization data with others, including but not limited, to my primary care physician, the authorizing physician, and the local Department of Health, and I authorize these disclosures.
3. I release SCGHD and its subsidiaries, affiliates, officers, directors, employees, and agents from all liability, including acts of omission or commission, resulting, or arising from my receipt of this vaccination.

X_____

Signature of Patient or Parent/Guardian of Minor Patient Date