Seneca County General Health District
Julie Richards, MA, LSW, LPCC/S, Health Commissioner
92 E. Perry St., Tiffin OH 44883
Phone: (419) 447-3691
Fax: (419) 448-5782
801 Kirk St., Fostoria OH 44830
Phone: (419) 435-4401
www.senecahealthdept.org

_____the undersigned parent, legal guardian, or person having legal custody of _____ do hereby authorize _____to represent me as Guardian and provide consent to the appropriate licensed health care provider of the Seneca County General Health District (SCGHD) to proceed with the administration of the appropriate vaccines based on age and the schedule recommended by the Center for Disease Control and Prevention (CDC) for my child, a minor, noted above.

It is mandatory that you send the child's shot record and current health insurance card along to the appointment.

	CHILD'S DATE OF BIRTH _____	Yes	No	N/A
1	Is the child sick today?	☐	☐	
2	Does the child have allergies to medications, food, a vaccine component (gelatin), or latex?	☐	☐	
3	Has the child had a serious reaction to a vaccine in the past?	☐	☐	
4	Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	☐	☐	
5	If your child is a baby, have you ever been told he or she has had intussusception?	☐	☐	☐
6	Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐	☐	
7	Does the child or family member have cancer, leukemia, AIDS, or any other immune system problems?	☐	☐	
8	In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease or psoriasis; or had radiation treatments?	☐	☐	
9	In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	
10	FEMALES: Is the child/teen pregnant or is there a chance she could become pregnant in the next month?	☐	☐	☐
11	If your child is between the age 1 to 6, has he/she been tested for lead poisoning with the past year?	☐	☐	☐
12	Has the child received any vaccines in the past 4 weeks?	☐	☐	

I have received a copy or had one made available to me through the Seneca County General Health District's web site and have read, or had read to me, the information contained in the appropriate Vaccine Information Statement (V.I.S.) about the disease(s) and vaccines(s) that my dependent will receive. I believe I understand the benefits and risks of the vaccine(s) to be received. (V.I.S. forms are located at https://www.cdc.gov/vaccines/hcp/vis/current-vis.html) I have had a chance to ask questions, (by calling the Seneca County General Health District office) which were answered to my satisfaction. I understand the required vaccine information for my dependent is being sent to a central registry at the Ohio Department of Health.

Parent, Guardian and Adults signatures are in recognition and acceptance of the content of this page

Parent/Guardian Signature: _____

Date_____/_____/_____

Telephone I may be reached at: _____

Adult bringing child to clinic Signature: _____

Date _____/_____/_____

Seneca County General Health District
Consent for Services

By my signature below,

I consent to the administration of nursing service(s) provided by Seneca County General Health District (SCGHD). I am of legal age and authorized to execute this consent form or I am the parent/guardian of the minor patient.

1. I understand that:
    - I have voluntarily chosen to receive the services 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.
    - Vaccine(s) offered will be determined, based on Center for Disease Control's (CDC) Recommended Immunization Schedule and a current vaccine record provided by the client/guardian.
    - 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(s), when the side effects may occur, also 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 the 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).
    - I acknowledge that I have received/read a copy of the Financial Policy. I understand and agree to the Financial Policy.
    - 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.
    - The patient/caregiver and Public Health Nurse (PHN) engaged in shared clinical decision-making about the benefits and risks of the requested vaccine(s). My questions were answered to my satisfaction and no contraindication to vaccination was identified. The patient/caregiver and the PHN collaboratively determined the patient would benefit from vaccination.
    - By sharing your mobile phone and email information with us, you agree to receive periodic text messages and emails with a link to access your account online, which allows you to view and pay for balances you are responsible for.
2. 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 service(s).

X_____

Signature of Patient or Parent/Guardian of Minor Patient Date