TAZEWELL COUNTY HEALTH DEPARTMENT GENERAL CONSENT FORM

Last Name: _____ Legal First Name: _____ Middle Initial: _____

Address: _____ City/Zip: _____ Phone: _____

Gender: Male Female Other Date of Birth: _____/_____/_____ Employer (if paying for services): _____

Insurance Information:

Insurance Name: _____ *(Examples: Molina, Medicare, Medicaid, Humana)*

Policy or Subscriber ID: _____ Group Number (if any): _____

Policy Holder's Name: _____ Date of Birth: ____/____/_____

VFC (Vaccinations for Children): Effective January 1, 2013, Tazewell County Health Department was required by law to administer VFC (state supplied) vaccine to only those children who are eligible. We are subject to random audits by the State of Illinois. Therefore, you will be asked to complete a series of questions identifying your VFC status. Every effort will be made to determine eligibility.	Eligible: You must have either Title XIX (19) Medicaid, be uninsured, be under-insured (NO VACCINE COVERAGE ON YOUR INSURANCE) and receiving VFC vaccine through a Federally Qualified Health Center (FQHC), be an American Indian belonging to a tribe, band or organized group recognized by the Secretary of State, or Eskimo, Aleut, or Alaskan Native.
317 (State-supplied Vaccinations for Adults) Eligibility: You must either be uninsured, be under-insured (NO VACCINE COVERAGE ON YOUR INSURANCE). Non-Eligible: Include, but are not limited to, out of network, a high deductible, your doctor's office does not offer vaccines, or your insurance does not cover a preferred vaccine (Brand name vs. Generic).	

If you declare eligibility to receive VFC vaccine or VFA vaccine and TCHD receives notification from an insurance carrier stating you have been reimbursed for services rendered or requesting further information from us to complete a claim, you will receive a statement for the cost difference between the fee for the VFC vaccine that you have already paid and the cost/administration fee for private pay vaccine that we stock.

Notice of Privacy Policy: (Please Initial)

_____I acknowledge receipt of Tazewell County Health Department's Notice of Privacy Policy.

Authorization to Release Information/ Continuity of Care /Financial Responsibility: (Please Initial)

_____I authorize the release of any medical information between my provider and TCHD for continuity of care. I authorize the release of any medical information to the Centers for Medicare and Medicaid Services (CMS), my insurance carrier(s), or other entities necessary to determine insurance benefits or benefits payable for related medical services provided to me by Tazewell County Health Department. I also understand insurance billing is a service provided by TCHD and I am responsible for the entire and/or balance of my bill once my insurance(s) have been billed if there is a balance. Regulations pertaining to Medicare and Medicaid assignment of benefits apply.

_____I authorize Tazewell County Health Department to release immunization data to my (child's) school district upon request.

Consent to Test/Treat/Provide Services:

I authorize Tazewell County Health Department to provide testing, administer treatment, or provide appropriate services as deemed necessary for the care of the patient named below. I certify that I am the patient, parent or legal guardian of the patient. I have read or have had explained to me information about the vaccines/services to be given today. I have had the opportunity to ask questions that have been answered to my satisfaction. I understand that this record will be maintained by the Tazewell County Health Department and immunizations will also be maintained in a confidential computerized immunization registry, and that I can choose to opt out of the registry by completing an "Opt Out of Registry" form at each immunization visit.
I understand I have the right to revoke this authorization by giving written notice to Tazewell County Health Department.
This authorization is in effect for one year from the date below.

Signature: _____ Printed Name of Signee: _____
(Parent or Legal Guardian if Patient is a minor)

Date: _____ Office Use Only: _____ PP _____VFC _____T21 _____317 5/2023

Person receiving vaccine: Last Name_____

First Name_____ Middle Initial: _____ Date of Birth: _____/_____/_____

	YES	NO	?
1. Is the patient sick today?.....	☐	☐	☐
2. Does the patient have allergies to food, drugs, latex, or vaccines?.....	☐	☐	☐
3. Has the patient has a serious reaction to a vaccine in the past?.....	☐	☐	☐
4. Has the patient had a health problem with lungs, heart, kidneys, diabetes, asthma, a blood clot disorder, or on long term aspirin therapy?.....	☐	☐	☐
5. If patient is a baby, has he/she had intussceptions?.....	☐	☐	☐
6. Has the patient, sibling, or parent had a nervous system disorder or seizures?.....	☐	☐	☐
7. Does the patient have cancer, leukemia, HIV/AIDS, or other immune problem?.....	☐	☐	☐
8. In the past **3 months**, has the patient taken cortisone, prednisone, steroids, anti-cancer drugs, or had radiation treatments?.....	☐	☐	☐
9. In the past **year**, has the patient received a blood transfusion, blood products, been given immune globulin, or an anti-viral drug?.....	☐	☐	☐
10. Has the patient received vaccinations in the **past 4 weeks**?.....	☐	☐	☐
11. FOR FEMALES-is the patient pregnant or will become pregnant in the next month?.....	☐	☐	☐

DO NOT WRITE BELOW THIS LINE

Given to patient/parent/guardian: _____VIS _____Imm. Records _____Return Date _____Comfort Care

VACCINE LOT NUMBER _____ _____PP _____VFC _____T21 _____317

☐ **Rotavirus**	☐ PO	☐ **Dtap**	☐ RAT ☐ LAT ☐ RD ☐ LD	☐ **Flu** ☐.25 ☐.5 ☐ **Nasal** ☐ **High Dose**	☐ RD ☐ LD ☐ RAT ☐ LAT
☐ **Pediarix** (Dtap/IPV/Hep B)	☐ RAT ☐ LAT ☐ RD ☐ LD	☐ **Polio**	☐ RAT ☐ LAT ☐ RD ☐ LD	☐ **Tdap**	☐ RD ☐ LD
☐ **Hib**	☐ RAT ☐ LAT ☐ RD ☐ LD	☐ **Kinrix** (Dtap/Polio)	☐ RD ☐ LD	☐ **HPV**	☐ RD ☐ LD
☐ **Hep B**	☐ RAT ☐ LAT ☐ RD ☐ LD	☐ **MMR** __ *Waiver signed*	☐ RA-SC ☐ LA-SC ☐ RT-SC ☐ LT-SC	☐ **Men 4-ACYW** ☐ **Men B**	☐ RD ☐ LD ☐ RD ☐ LD
☐ **Prevnar 13** ☐ **Prevnar 20**	☐ RAT ☐ LAT ☐ RD ☐ LD	☐ **MMRV** __ *Waiver signed*	☐ RA-SC ☐ LA-SC	☐ **Pneumonia 23**	☐ RD ☐ LD
☐ **Hep A**	☐ RAT ☐ LAT ☐ RD ☐ LD	☐ **Varicella**	☐ RA-SC ☐LA-SC ☐ RT-SC ☐LT-SC	☐ **Shingles**	☐ RD ☐ LD

Administering Nurse Signature_____ Date:_____