Patient name: _____ Date of birth: ____/____/____ (mo.) (day) (yr.)

Screening Checklist for Contraindications to Vaccines for Children and Teens

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Is the child sick today?	☐	☐	☐
2. Does the child have allergies to medications, food, a vaccine component, 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 the child to be vaccinated is between the ages of 2 and 4 years, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐	☐	☐
6. If your child is a baby, have you ever been told he or she has had intussusception?	☐	☐	☐
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐	☐	☐
8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
9. In the past 3 months, has the child taken medications that weaken their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?	☐	☐	☐
10. 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?	☐	☐	☐
11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐	☐
12. Has the child received vaccinations in the past 4 weeks?	☐	☐	☐

Form completed by: _____ Date: _____

Form reviewed by: _____ Date: _____

Did you bring your child's immunization record card with you? **yes** ☐ **no** ☐

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.

Technical content reviewed by the Centers for Disease Control and Prevention

www.immunize.org/catg.d/p4060.pdf • Item #P4060 (10/12)

KENTON HARDIN HEALTH DEPARTMENT

Patient Information Form

Name of Patient_____Social Security Number_____

Birthdate_____Age_____ ☐Male ☐ Female Race: White/Black/Other

Address_____

Phone#_____(or Contact #_____Name_____)

Mother/Guardian's Name_____Birthdate_____

Address_____

Social Security Number_____Employer_____

Father/Guardian's Name_____Birthdate_____

Address_____

Social Security Number_____Employer_____

INSURANCE INFORMATION

AS A COURTESY we will bill your primary and secondary insurance carrier if you provide **ALL** the necessary information.

A $25.00 FEE WILL BE CHARGED FOR ALL RETURNED CHECKS.

PRIMARY INSURANCE

Insurance Name:_____

Policyholder Name_____

Policyholder DOB_____

ID #_____

Group #_____

SECONDARY INSURANCE

Insurance Name:_____

Policyholder name_____

Policyholder DOB_____

ID#_____

Group #_____

I have read and received the HIPAA Privacy Act. _____.

Signature Date

I give Kenton Hardin Health Department consent to give information to the following people and/or bring my child in for services.

Name	Relationship to patient
_____	_____
_____	_____
_____	_____
_____	_____

KENTON-HARDIN HEALTH DEPARTMENT

Patient Information Form

Self Pay Yes/No

Do you have Dental Insurance? Yes/No

Do you have Vision Insurance? Yes/No

Family or Child's Primary Care Physician_______________________________________

Address_________________________________Phone#_____________________

Family or Child's Dental Provider____

Address_________________________________Phone#_____________________

Family or Child's Vision Provider____

Address_________________________________Phone#_____________________

School

Does your child attend school? ☐ yes ☐ no

If yes, what school does your child attend?_____________________________________

Is your child in the appropriate grade for their age?_______________________________

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Name of person completing this form____

Relationship to child__________________________Date Completed_________________

Revised 4/25/2013

Revised 7/3/2013 (patient demo form)

KENTON-HARDIN HEALTH DEPARTMENT

Kenton Hardin Health Dep t
175 W. Franklin St., Suite 120
Kenton, OH 43326
419.673.6230
419.673.8761 FAX

Public Health
Prevent. Promote. Protect.

PATIENT FINANCIAL RESPONSIBILITY FORM

Patient Name:_____DOB_____

We are pleased to assist you with your services and your insurance policy. Your insurance policy is a contract between you and your carrier. We will be more then happy to submit claims to your carrier as long as you give us the correct information. Please understand that you will be responsible for any charges incurred by not providing the most current, correct insurance to Kenton Hardin Health Department _____ please initial

Deductible/Co-Insurance:

If my insurance carrier determines that I have not met my deductible or I have a co-insurance I understand that I will be fully responsible for payment in a timely manner, no more than 30 days after I have been notified by my insurance or provider._____ please initial

No Call/No Show:

If you no call or no show for a scheduled appointment you will be billed $15.00 for the appointment. _____ please initial

I acknowledge that I assume full financial responsibility for services rendered to me or my child, if my insurance carrier denies or does not cover my claim for these services. I understand the terms of this form and accept financial responsibility with or without the use of insurance coverage. _____ please initial

Authorization to pay benefits to Kenton Hardin Health Dept:

I authorize payment for medical services provided directly to the Kenton Hardin Health Dept. _____ please initial

Patient/Guardian Signature_____

Relationship_____

Date_____

KENTON-HARDIN HEALTH DEPARTMENT

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175 W. Franklin St., Suite 120
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Public Health
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CONSENT FOR SERVICES

Patient Name_____ **Date of Birth**_____
Please respond to the following questions for the patient that is being seen.

Yes No Is the patient enrolled in Medicaid?
Yes No Does the patient have private health insurance?
Yes No Does the health insurance cover vaccines?
Yes No Is the patient American Indian or Alaskan Native?

I have received and/or read, and understand your notice of Privacy Practices regarding the uses and disclosure of the health information for me and/or my child. I grant permission for the record to be released to medical providers, health departments, schools and day care centers. I have received a copy, have read or had read to me the information on the appropriate VIS sheet about vaccine(s) and my questions were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) be administered to me or the person named for who I am authorized to make this request.

I authorize **(name of insurance company)**_____to assign the amount payable under the client's contract directly to the KHHD. I understand that I am financially responsible for all the charges that are not covered under the client's insurance plan.

I understand that I am responsible for notifying the KHHD if there is a change in the insurance coverage or funding status.

PROOF OF INCOME FOR NON-ISSUED: I herby acknowledge that the information given herein regarding income and household size is true and accurate. If not I will be responsible for 100% (full cost) of services received or provided. Incomplete, inaccurate or fraudulent information could result in legal action. I agree to comply and sign the IRS 4506-T form if I am declaring no income.
I,_____ state that there are ____people living in my household and we have no income.

SLIDING FEE SCALE AGREEMENT: If payment for other services is determined by and based on a sliding fee scale, I understand that I am responsible for my share of the cost of service rendered and that failure to provide "proof of income" will result in being charged 100% of all the cost of services rendered.

Print Parent/Legal Guardian Name_____Date_____

Parent/Legal Guardian Signature_____Relationship to Patient_____

Witness Signature_____Date_____