FRANKLIN COUNTY HEALTH DEPARTMENT
100 Glenns Creek Road, Frankfort, KY 40601

County Code: 037

OFF SITE IMMUNIZATION REGISTRATION

1. _____ 2. | | | | - | | | - | | | | |
Last Name First Name Middle Initial Social Security #

3. _____
Local KY Address (Mailing) City County State Zip

4. _____ 5. _____ 6. _____
Date of Birth Number in Household Phone Number

7. Race (Check One): ◯ 1. White-Non Hispanic ◯ 2. Black-Non Hispanic ◯ **3. American India** ◯ **4. Oriental**
◯ **5. Hispanic-White** ◯ **6. Hispanic-Black**

8. Sex: Click to select

9. Do you have health insurance? Click to select Insurance Co. _____

Subscriber Name _____ Patient Relation _____

Policy ID Number _____ Group Number _____

10. Do you have Medicare? Click to select Card Number _____

11. Do you have Medicaid? Click to select Card Number _____

_____

CONSENT FOR HEALTH SERVICES (Expires 1 Year from Date Signed)
Of my own free will I consent to care which may include screening, exams, lab tests, treatment, medicine, x-ray and any other health service given to me by staff or agents of this health department. I understand that no Guarantees are being made as to the effect of any exam or treatment on me. I also understand I may be tested for (HIV) infection, Hepatitis B, or any other disease carried by blood or body fluids if such a test(s) is needed for diagnosis, to assist in my medical treatment, or if a health care worker is exposed to my blood, body fluids or tissue.

PAYMENT FOR SERVICES / ASSIGNMENT OF BENEFITS
_____ I request that payment of authorized medical insurance benefits be made to Franklin County Health Department on my behalf, for services that I receive. I also authorize the local health department to release medical information about me to Medicare, insurance and other third-party payers to determine payment of services.

_____ My employer agrees to reimburse the Franklin County Health Department for services provided today. My service today is a requirement of my employer.

_____ I have read the above and have had an opportunity to ask questions. I understand the item checked above as it applies to me. My signature below indicates that I do consent, authorize or declare as stated above.

My signature below acknowledges that I am aware of Franklin County Health Department's "NOTICE OF PRIVACY PRACTICES" (FCHD-HP1) effective April 14, 2003 and I understand that I may ask for a copy or access a copy at www.fchd.org.

WITNESS: _____ _X_____ _____
(If Patient Cannot Sign) *Signature of Patient or Other Authorized Person* *Date*

FCHD-05C
Revised 03-2014

L label

PLACE OF SERVICE: M (Patient's Home) O (Other Unlisted Facility) ___ Health Department

Presents for IMMUNIZATION UPDATE----------

Immunization Status __presents for Hep A__ _____ Date of Last Vaccination _____

Allergies _____ Current Medications _____

Steroidal / Immunosuppressive Meds? _____ Sick Today? _____

Recent Illness _____ Recent Blood Transfusion _____

Neurological Problems _____

Pregnant? _____ Chance of Becoming Pregnant? _____

Age _____ Sex _____ Race _____ A & O x 4 _____Temp _____

Skin: Warm, Dry, Pink, No Rashes Noted _____Well Nourished, Well Developed, FROM _____

Counseled on: VIS (Reviewed & Given) _____ Post-Vaccination Care _____

Immunizations Given ___Hep A_____

~~Titer Drawn (Site) _____ Tolerated Well? _____~~ RTC __6 months for 2nd dose of HEP A__

Provider Signature & # _____ Date _____

I have read or had read to me information about the vaccine(s) listed below. I have been given the Vaccine Information Statement(s) for the vaccine(s). I have had a chance to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) to be administered and ask that the indicated vaccine(s) be given to me or the patient. I also give permission to share my immunization record with facilities or institutions, which are required by law to have such records, and with my other health care provider(s).

Vaccine	VIS Date	Manufacturer / Lot #
❑ Varicella	_____	_____
❑ DT ❑ DTaP	_____	_____
✠ Hepatitis A	_07/20/2016__	_____
❑ PCV13	_____	_____
❑ PPV23	_____	_____
❑ Meningococcal	_____	_____
❑ Rotavirus	_____	_____
❑ HPV	_____	_____
❑ Twinrix	_____	_____
❑ Rabies	_____	_____
❑ Titer (Specify)	_____	
❑ Titer (Specify)	_____	

Vaccine	VIS Date	Manufacturer / Lot #
❑ IPV	_____	_____
❑ MMR	_____	_____
❑ Influenza	_____	_____
❑ Influenza (LIVE)	_____	_____
❑ Hib	_____	_____
❑ MMRV	_____	_____
❑ Hepatitis B	_____	_____
❑ Td	_____	_____
❑ Tdap	_____	_____
❑ Shingles	_____	_____
❑ Other (Specify)	_____	_____

_____ _____

Signature of Patient or Other Authorized Person *Date*

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