Public Health
Prevent. Promote. Protect.
Tuscarawas County Health Department

TUSCARAWAS COUNTY HEALTH DEPARTMENT
INFLUENZA/PNEUMONIA/RSV/ COVID-19 CLINIC FORM

PLEASE PRINT

Information needed for the person who will be receiving the vaccine:

Last Name: _____ First Name: _____ MI_____
Date of birth: _____ SSN: _____ Age: _____ Sex: _____
Address: _____
City: _____ County: _____ State: _____ Zip _____
Home Phone: _____ Cell Phone: _____

Insurance Information

Subscriber's Name: _____ Relationship to the patient: _____
Subscriber's DOB: _____ Subscriber's SSN: _____

For Patients Under 18 Years Old:

Parent/Guardian Name: _____ DOB: _____ SSN: _____

Consent/Notice of Privacy

I understand that the services provided today may not be covered by my insurance company. If it is determined that I am not eligible for coverage and no benefits exist for my claim, I understand that I will be responsible for payment of all services provided.

I have received information concerning influenza, pneumonia, COVID-19, or RSV vaccines. I was given a chance to ask questions about the influenza and pneumonia or RSV vaccines. I understand the benefits/risks of the vaccine. I ask the influenza, pneumonia, COVID-19, or RSV vaccine be given to me or to the person named on this form for whom I am authorized to request. I have been offered and/or received a copy of the Notice of Privacy Practices, confirmed by my signature below.

Patient/Parent/Guardian Signature: _____ Date: _____

TCHD Staff will complete this section.

Vaccine Used: PRIVATE VFC 317

INFLUENZA	PNENAR	COVID-19	RSV

_____Impact ____EHR ____Zip Code ____Primary ____Valid _____Staff Initials

VFC ONLY: The patient named above qualifies for immunization through the VFC program because he/she or his/her parent/guardian states the child is 18 years of age or younger and:
_____is Medicaid eligible or has Medicaid.
_____is uninsured (does not have private insurance/self-pay)
_____is an American Indian or Alaskan Native
_____Health insurance does not cover vaccines (only at federal and rural health centers)
_____***The patient does not qualify for immunizations through VFC program because he/she has health insurance that pays for vaccines.***

ADULT 317 ONLY:
____Uninsured
____Underinsured: *Name of Insurance*_____ *Phone number*_____
Verified requested vaccine is not covered: _____

9/22/23ak; 10/10/23ak9/9/25ak