VACCINATION CLINIC FOR LANCASTER CITY SCHOOLS

REGISTRATION FORM

Student Name:		**DOB:**
Street Address:	**City**	**Zip:**
Phone:	**Email:**	**Race/Ethnicity:**

Parent/Guardian Name:		**Relationship to Patient:**
Street Address:	**City**	**Zip:**
Phone:	**Email:**	

Primary Care Physician Name:		**Phone:**
Street Address:	**City**	**Zip:**

I hereby give my permission to the Fairfield Department of Health and FCHC to administer the following vaccinations to my child:

Kindergarten:

__ Dtap/Polio Combo Required

__ MMR Required

----Chicken Pox Required

__ I DO NOT wish for my child to receive vaccinations.

7th Grade:

__ Tdap (Boostrix) Required

__ Men ACYW (Menveo) Required

----I DO NOT wish for my child to receive vaccinations.

12th Grade:

__ Men ACWY (Menveo) Required

__ Men B (Bexsero) Recommended

---- I DO NOT wish for my child to vaccinations.

Parent/Guardian Signature:_____ **Date:**_____

A

I acknowledge that I have reviewed a copy of the Notice of Privacy Practices provided to me by the Fairfield Community Health Center. I understand that this Notice explains what FCHC does to protect the use or disclosure of my health care information. I understand that I will be given a copy of this Notice and will refer to it if I have questions. I also understand that I should call FCHC at (740) 277-6043 if I have questions or concerns about my privacy rights.

- I understand that this service(s) may or may not meet the criteria for coverage under Medicaid, and/or other insurance carriers.
- I understand that if Medicaid, and/or other insurance carriers cover the service(s), I will only be responsible for unpaid coinsurance/deductible charges.
- I understand that if Medicaid and/or other insurance carriers fail to cover the service(s), I must pay the full amount of the charges.

I have read the above and have had the opportunity to discuss this matter and any questions with FCHC staff. My signature indicates that I agree to pay all charges regarding this service(s) if Medicaid, and/or other insurance carriers fail to cover the charges.

_____ _____

Signature of Patient/Responsible Party **Date**

- **Please complete the information below as well as a picture of the front and back of your insurance card. If you are a <u>self- pay individual you will be charged an administration fee of $21.68 for each immunization</u>. If unable to pay fees, please call Annette Blackford (740) 277-6043 prior to scheduled clinic.**

Medicaid Managed Care Plans *(check one below):*

Managed Care ID#:_____

☐ buckeye health plan ☐ CareSource

☐ PARAMOUNT ☐ MOLINA HEALTHCARE

☐ UnitedHealthcare Community Plan **Medicaid UHC not offered by your job*

☐ Healthy Start Healthy Families **Ohio Medicaid#**: _____

☐ **The student does not have health insurance.**

Private Insurance (other than Medicaid):

Insurance company: _____

Subscriber ID or member #: _____

Group #: _____

Name of person under whom child is covered:

_____

Birth date of insured adult: ____

Phone # on insurance card: ____

Claims address on insurance card: _____

SIGN HERE: I am unable to pay for health services.

X_____

Vaccines for Children Eligibility Criteria

	Yes	No
1. Receive Medicaid	☐	☐
2. Uninsured	☐	☐
3. American Indian / Alaska Native	☐	☐
4. Underinsured – defined below*	☐	☐

For Office Use Only:

Immunization	Lot #	Exp Date	Site	Nurse
Dtap/Polio			**LD** RD	
Varicella			**LD** RD	
MMR			**LD** RD	
Men ACWY			LD RD	
Men B			**LD** RD	
Tdap			**LD** RD	