Medina County Board of Developmental Disabilities
Administration & Consent Form Immunization Clinic

SECTION 1: DEMOGRAPHIC INFORMATION

Patient Name:_____ Date of Birth:_____/_____/_____ Age:_____

Parent/Guardian Name:_____ Phone Number:_____

Address:_____ SSN:_____

City:_____ State:_____ Zip Code:_____ County:_____

Allergies:_____ Gender:_____

Primary Care Physician:_____ PCP Phone Number:_____

Race: ☐White ☐Black/African American ☐Hispanic ☐Asian ☐American Indian/Alaskan Native
☐Native Hawaiian/Other Pacific Islander ☐Other:_____ ☐Prefer Not to Answer

Ethnicity: Are you of Hispanic, Latino, or Spanish origin?

☐Yes-Please specify:_____ ☐No-Not of Hispanic, Latino, or Spanish origin

SECTION 2: VACCINES REQUESTED (circle all for administration at this visit):

COVID Influenza (Flu) Hepatitis A Hepatitis B Hepatitis A &B Pneumonia RSV Tdap Zoster (Shingles)

SECTION 3: SCREENING QUESTIONS & AUTHORIZATION

	YES	NO
1. Are you sick today?		
2. Do you have allergies to medication, food, latex, or any vaccine component? Please list:		
3. Have you ever had a serious reaction after receiving a vaccine?		
4. Do you have any have any of the following: long term health problem with heart, lung, kidney or metabolic disease (i.e. diabetes), asthma, blood disorder, no spleen, cochlear implant, spinal fluid leak, cancer, leukemia, HIV/AIDS, or on long term aspirin therapy?		
5. Do you or anyone who lives with you have an immune system problem?		
6. In the past 6 months, have you taken medications that affect your immune system (prednisone, other steroids, anticancer drugs, drugs to treat rheumatoid arthritis, Crohn's disease, or psoriasis, or have received radiation treatments)?		
7. Have you had a seizure, brain, or other nervous system problem?		
8. Have you been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the COVID-19 virus?		
9. In the past year, have you received immune (gamma) globulin, blood/blood products, or an antiviral drug?		
10. Have you received any vaccines in the past 4 weeks?		
11. Are you pregnant, plan to get pregnant, or nursing/breast feeding?		

For **MEDICARE** or INSURANCE recipients: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to Discount Drug Mart. If a claim rejects, I will be charged cash. For patient reimbursement, the patient must submit their Cash Receipt to their major medical benefits provider. I have read or have had explained to me the information in the Vaccine Information Statement (VIS) about the vaccine(s) I circled above. I have had a chance to ask questions that were answered to my satisfaction. I attest that I meet the requirements to receive the selected vaccine(s) to be administered and I understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) be given to me or the person named below for whom I am authorized to make this request. I agree to receive treatment for any adverse event that may occur after receiving the vaccine(s) while on site. In the event of an accidental post vaccination needle stick to the vaccine administrator, I agree to be contacted for follow up lab work. I have received the Discount Drug Mart NOPP.

DATE: _____

SIGNATURE OF PATIENT (IF PATIENT IS 18 YEARS OF AGE OR OLDER): _____

SIGNATURE OF PARENT OR LEGAL GUARDIAN AUTHORIZING VACCINATION
(IF PATIENT IS YOUNGER THAN 18 YEARS OF AGE): _____

BILLING INFORMATION

CIRCLE ONE: EMPLOYER INVOICE CASH PRESCRIPTION PLAN MAJOR MEDICAL

MEDICARE B MEDICARE D EMPLOYEE INVOICE

PLAN NAME:_____

MEDICAL ID:_____ **MEDICAL GROUP:**_____

RX BIN:_____ **RX PCN:**_____

RX ID:_____ **RX GROUP:**_____

RELATIONSHIP (CIRCLE ONE): HOLDER SPOUSE CHILD DEPENDENT

*****FOR PHARMACY USE ONLY*****

Vaccine Name and Manufacturer (Clinic Use) / Rx Number (Corp Use)		Dose Quantity	Dose Number	Route	Site	Lot and Expiration Date
				IM SC	L Arm R Arm	
				IM SC	L Arm R Arm	
				IM SC	L Arm R Arm	

Vaccine Administrator Attestation: I confirmed the patient to be vaccinated's name, DOB, and vaccine(s) to be administered. I reviewed the Screening Questions and addressed any concerns identified by myself or the patient.

Signature and Title of Vaccine Administrator:_____

Printed Name:_____ Date:_____

Physician on Record:

R. Douglas Bruce, MD, MBA, MA, MS
2500 MetroHealth Drive Cleveland, OH 44109

Billing:

131:

- ***Aetna Commercial ONLY***-Flu
- ***Aultcare SERS & STRS-***COVID, Flu, Pneumonia, Shingrix
- ***Cigna***-Flu, Pneumonia
- ***MMO (NO MEDICARE SUPPLEMENT)***-COVID, Flu, Pneumonia, RSV, Shingrix
- ***PrimeTime***-COVID, Flu, Pneumonia
- ***Summa***-Flu, Pneumonia

499: MMO Flu Clinic (FLU ONLY)
2083: ***Aetna B-***COVID, Flu, Pneumonia
3130: ***Medicare B-***COVID, Flu, Pneumonia

All others: Rx Benefit or Cash

Always try online card first

Scan copies of all current insurance cards into patient profile

ICD-10 CODE: Z23

PH, MA, 3N in DUR Code Section for Rx Benefit billing