Clinic Date:

Hepatitis A Vaccination Clinic

ST. CLAIR COUNTY HEALTH DEPARTMENT
Our Community. Our Environment.

PRINT CLEARLY

Last Name:_____ Birth Date: **Month**____ **Day**_____ **Year** _____ Age:_____

First Name:_____ Middle Initial: _____ Sex: ☐ Male ☐ Female

Phone Number: _____ Mobile (Cell) Number:_____

Address:_____ City:_____ Zip:_____

Health History Questions (Must be Answered)	**Yes**	**No**
1. Have you been out of the United States in the last 30 days?		
2. Are you sick today?		
3. Do you have allergies to medications, food, a vaccine component, or latex?		
4. Have you ever had a serious reaction after receiving a vaccination?		
5. Are you a food worker?		
6. For women: Are you pregnant?		

Race (Check only one box)

☐ Arabic
☐ Asian
☐ Black/Africa American
☐ White / Caucasian
☐ Native Hawaiian/Pacific Islander
☐ American Indian/Alaska Native
☐ More than one Race
☐ Other

Annual Income Level

☐ 0-$15,000
☐ $15,000 - $25,000
☐ $25,000 - $35,000
☐ $35,000 - $50,000
☐ $50,000 - $75,000
☐ $75,000 - $100,000
☐ $100,000 +

Family Size: ☐

****There will be NO charge to any individual for this service****

Your insurance information will be used to bill your insurance; if you do not have active coverage or the services are not covered you will not be billed.

☐ I HAVE NO INSURANCE (*AVP*)

☐ I HAVE MEDICARE / MEDICARE ADVANTAGE (*AVP*) ***(No cards needed)***

☐ I HAVE MEDICAID / MEDICAID HEALTH PLAN *(PP)* ***(No cards needed)***

☐ I HAVE PRIVATE INSURANCE *(PP)* ***(Have card available to scan)***

I authorize the release of any medical or other information necessary to process this claim. I also request payment of benefits to the party who accepts assignment. Information related to the service may be sent to the address I have provided. St. Clair County Health Department Notice of Information Practices has be received and I have been given a copy and have read, or have had explained to me, the appropriate Vaccine Information Statement(s) (VIS) about the disease(s) and the vaccine(s), which are to be administered today. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the specific vaccine(s). I ask that the vaccine(s) I have requested be given to me, or to the person named above for whom I am authorized to make this request and I ask that the administration of the vaccine(s) be recorded on this form and in MCIR.

Date: **Signature:** _____

For office use only: ☐ Document scanned Initials:_____