Fresno County Department of Public Health - Immunization Program
Registration Consent Form

Patient Information

Date of Service _____ CAIR# _____

Last Name _____ First Name _____

DOB (mm/dd/yyyy) _____ Age _____ Sex _____ Mother's First Name _____

Address _____ Apt # _____ City _____ Zip _____

Place of Birth _____ Phone _____ Email Address _____

ETHNIC GROUP
- □ Hispanic
- □ Non-Hispanic
- □ Unknown

RACE
- □ Asian
- □ Black/ African American
- □ White
- □ Other _____
- □ Alaskan Native
- □ American Indian
- □ Native Hawaiian
- □ Pacific Islander

LANGUAGE
- □ English
- □ Spanish
- □ Hmong
- □ Other _____

Responsible Person

☐ Same as Patient ☐ Parent ☐ Foster Parent (**guardianship papers required**) ☐ Legal Guardian (**guardianship papers required**)

Last Name _____ First Name _____

Address _____ Apt # _____ City _____ Zip _____

Phone _____ Email Address _____ Language Spoken _____

Primary Care Provider Information

Name of Primary Care Clinic _____ Clinic Phone Number _____

Name of Primary Care Provider _____

What are vaccinations needed for? *(select all that apply)*

☐ Routine Vaccination ☐ Past Due Vaccination ☐ School/Work Required Vaccination

☐ Travel Related Vaccination ☐ Required Immigration Vaccination

Health Insurance and Eligibility Information *(select one)*

If you are eligible for VFC/317, and unable to provide payment for services today, you will NOT be turned away. Please speak with receptionist at the window.

Private Insurance Children and Adults

The Immunization Program does not have a mechanism in place to bill Private Insurance. If your child is covered under private insurance, you may have to pay out of pocket.

☐ Private insurance

(Note: Private pediatric doses are generally limited to: Tdap, Varicella, MMR, and Polio; please check with clinic staff to confirm availability.)

VFC Eligibility (Children 18 years and under)

The following statements will help us determine if your child may receive immunizations through the Vaccine for Children (VFC) Program.

Please check applicable box below for child receiving immunization:

☐ 1. Has Medi-Cal or Child Health & Disability Program (CHDP)

☐ 2. Child is Uninsured (does not have health insurance)

☐ 3. Child is an American Indian or Alaskan Native

317 Eligibility (Adults 19 years and over)

The following statements will help us determine if you may receive immunizations through the State 317 program.

Please check applicable box below for adult receiving immunization:

☐ 1. Person is uninsured (does not have private health insurance)

☐ 2. Person is underinsured, patient has health insurance, but it:
- Doesn't cover vaccines or
- Doesn't cover certain vaccines or
- Covers vaccines with a fixed dollar limit which has been reached

For Office Use Only

Consent for Vaccination

I have been given a copy and have read, or have had explained to me, the information contained in the Vaccine Information Statement(s) or the appropriate Important Information Statement(s) about the disease(s) and vaccine(s) indicated below. I have had an opportunity to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated below be given to me or the child/adult named above for whom I am authorized to make this request.

Print Name _____ Signature _____ Date _____

□ COVID	□ Influenza	□ PCV	□ Rotavirus	□ Yellow Fever
□ DTaP	□ JYNNEOS	□ Pediarix (DTaP, HepB, & IPV)	□ Shingrix (Shingles)	□ _____
□ Hep A	□ Kinrix (DTaP & IPV)	□ Polio	□ Tdap	□ _____
□ Hep B	□ MenACWY	□ PPD (TB Skin Test)	□ Twinrix (Hep A & B)	□ _____
□ Hib	□ Meningitis B (Bexero)	□ PPSV23	□ Typhoid	□ _____
□ HPV	□ MMR	□ Proquad (MMRV)	□ Varicella	□ _____

Type of Insurance

□ Not Insured
□ Private Insurance
□ Medi-Cal
□ Anthem Blue Cross (Managed Care)
□ Health Net/Cal-Viva (Managed Care)
□ Underinsured - **18 and under** *must be referred to a FQHC or RNC*
□ Underinsured - **19 and over** *317 eligible with proper documentation*

Vaccine Type *(select all that apply)*

□ VFC □ 317 □ State □ Private

Form of Payment

□ Medical □ Cash □ Check □ CC □ Fee Reduction (**form attached**) □ Waiver (**form attached**)