



## 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 \_\_\_\_\_

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 \_\_\_\_\_

- |                                |  |   |  |                                       |
|--------------------------------|--|---|--|---------------------------------------|
| <input type="checkbox"/> COVID | <input type="checkbox"/> Influenza             | <input type="checkbox"/> PCV13                        | <input type="checkbox"/> Rotavirus           | <input type="checkbox"/> Yellow Fever |
| <input type="checkbox"/> DTaP  | <input type="checkbox"/> JYNNEOS               | <input type="checkbox"/> Pediarix (DTaP, HepB, & IPV) | <input type="checkbox"/> Shingrix (Shingles) | <input type="checkbox"/> _____        |
| <input type="checkbox"/> Hep A | <input type="checkbox"/> Kinrix (DTaP & IPV)   | <input type="checkbox"/> Polio                        | <input type="checkbox"/> Tdap                | <input type="checkbox"/> _____        |
| <input type="checkbox"/> Hep B | <input type="checkbox"/> MenACWY               | <input type="checkbox"/> PPD (TB Test)                | <input type="checkbox"/> Twinrix (Hep A & B) | <input type="checkbox"/> _____        |
| <input type="checkbox"/> Hib   | <input type="checkbox"/> Meningitis B (Bexero) | <input type="checkbox"/> PPSV23                       | <input type="checkbox"/> Typhoid             | <input type="checkbox"/> _____        |
| <input type="checkbox"/> HPV   | <input type="checkbox"/> MMR                   | <input type="checkbox"/> Proquad (MMRV)               | <input type="checkbox"/> Varicella           | <input type="checkbox"/> _____        |

### Type of Insurance

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Not Insured                        | <input type="checkbox"/> Medi-Cal                         | <input type="checkbox"/> Underinsured - <b>18 and under</b> <i>must be referred to a FQHC or RNC</i>     |
| <input type="checkbox"/> Private Insurance                  | <input type="checkbox"/> Anthem Blue Cross (Managed Care) | <input type="checkbox"/> Underinsured - <b>19 and over</b> <i>317 eligible with proper documentation</i> |
| <input type="checkbox"/> Health Net/Cal-Viva (Managed Care) |   |  |

### Vaccine Type *(select all that apply)*

- ☐ VFC    ☐ 317    ☐ State    ☐ Private

### Form of Payment

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