Wyandot County Public Health
127- A South Sandusky Avenue
Upper Sandusky, OH 43351
Phone 419-294-3852 | Fax 419-294-6424
www.wyandothealth.com

COVID-19 Immunization Screening Consent Form

(Ages 12 years and older) - SpikeVax/Moderna 23-24 Formulation

PLEASE PRINT CLEARLY

Last Name: **First Name:** **M.I.:**

Address: **City:** **State:** **Zip:**

Phone Number: **Race/Ethnicity:** **Email:**

Birth Date: **Age:** **Sex (circle):** Male Female

Primary Care Physician: **Primary Care Physician Phone #:** **Parent/Guardian Name:**

By signing below, I acknowledge that I have read (or have had explained to me) the information regarding Covid-19 disease and the Covid-19 vaccine. I had the opportunity to ask questions that were answered to my satisfaction and received a Vaccine Information Sheet. I understand some Covid-19 vaccine is still available under EUA and others have received full FDA approcal. I understand the risk of the Covid-19 vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request. I understand information regarding my vaccine may be transferred to the Ohio Department of Health Immunization Program. I acknowledge that I have been offered or received a copy of the notice of privacy practices for Wyandot County Public Health (WCPH). I give my consent to use and disclose my protected health information for the purposes of treatment and payment of my health care. My signature also displays my understanding that I am responsible to provide payment of all charges at the time of service.

Patient or Guardian Signature _____ **Relationship to Patient** _____

Date Signed_____

For Office Use Only

INSURANCE

Medicaid (ex.Traditional Medicaid, CareSource, Molina, Buckeye,)

Insurance Name:_____ Member ID:_____

Primary / Secondary

Private Insurance (ex: Anthem, MMO, UMR,)

Insurance Name:_____ Member ID:_____

Primary / Secondary

Insurance copied	Insurance on file	VIS Date
Yes / No	Yes / No	10/19/2023

Medicare: Member ID_____

Staff initials

Medicare Suppliment:

Insurance Name: _____ Member ID:_____

HMO / PPO

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To be completed by nurse administering vaccine:

Date	Vaccine Name	Vaccine Lot #	Expiration Date	Manufacturer	IM Site	Dose	Staff initials
	Spikevax/Moderna (12 yrs+)			**Moderna**	LD / RD	**0.5 mL (50 µg)** dark blue cap, blue label	

Clinic Site:	Circle One		
	Private	VFC	317