FLORIDA DEPARTMENT OF HEALTH IN ORANGE COUNTY
IMMUNIZATION SCREENING AND CONSENT FORM

Date:

SECTION 1: INFORMATION - PLEASE PRINT

Last Name	First Name	Middle Name

Date of Birth			Age in Years:	Sex (Gender assigned at birth)
Month	Day	Year		☐ Male ☐ Female

Race			Ethnicity
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American	☐ Native Hawaiian or Other ☐ Pacific Islander ☐ White	☐ Other Asian ☐ Other Nonwhite ☐ Other Pacific Islander ☐ Other	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Address			
City	**State**	**Zip Code**	**Phone Number**

SECTION 2: SCREENING FOR VACCINE ELIGIBILITY

If you answer "yes" to any question, it does not necessarily mean the client should not be vaccinated.

Please check YES or No for each question	YES	NO
1. Are you sick today? Have you had a fever in the last 24 hours (greater than 100.4°)?		
2. Do you have any allergies to **medications, food, a vaccine component, environment or latex**? Please explain:		

Allergen(s)		Date of onset	
Reaction(s)		Severity ☐ Mild ☐ Moderate ☐ Severe	
3. Have you ever had a **serious reaction** to a vaccine in the past?			

Signature of Patient: _____ **Date:** _____

Following fields are for office use only.

Site (LD/RD)	Route	Manufacturer (MVX)	Lot #Unit of Use/ Unit of Sale	Expiration Date	Date of EUA Fact Sheet
	IM				

Administered at Location (Facility Name):					
Vaccinator (Print Name):		Signature:		Date:	

HMS MRN	FLShots ID # (State Imm ID)	Registration Clerk

INITIATION OF SERVICES

PART I **CLIENT-PROVIDER RELATIONSHIP CONSENT**

Client Name: _____

Name of Agency: **Florida Department of Health - Orange**

Agency Address: **6101 Lake Ellenor Drive, Orlando, Florida 32809**

I consent to entering into a client-provider relationship. I authorize Department of Health staff and their representatives to render routine health care. I understand routine health care is confidential and voluntary and may involve medical visits including obtaining medical history, assessment, examination, administration of medication, laboratory tests and/or minor procedures. I may discontinue this relationship at any time.

_____By initialing this line, I acknowledge that I have been provided with a Telehealth Informed Consent Informational Sheet and that I consent to the provision of some services to be provided by means of telehealth. I may withdraw my consent at any time by discontinuing the use of telehealth services without affecting my right to future care or treatment.

PART II **DISCLOSURE OF INFORMATION CONSENT** (treatment, payment or healthcare operations purposes only)

I consent to the use and disclosure of my health information; including medical, dental, HIV/AIDS, STD, TB, substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and health care operations. Additionally, I consent to my health information being shared in the Health Information Exchange (HIE), allowing access by participating doctors' offices, hospitals, care coordinators, labs, radiology centers, and other health care providers through secure, electronic means. If you choose not to share your information in the HIE, you may opt out by requesting and signing an HIE Opt-Out form.

PART III **MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST** (Only applies to Medicare Clients)

As Client/Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release my health information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the above-named agency and authorize it to submit a claim to Medicare for payment.

PART IV **ASSIGNMENT OF BENEFITS** (Only applies to Third Party Payers)

As Client /Representative signed below, I assign to the above-named agency all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personally responsible for charges not covered by this assignment.

PART V **COLLECTION, USE OR RELEASE OF SOCIAL SECURITY NUMBER**

(This notice is provided pursuant to Section 119.071(5)(a), Florida Statutes.)

For health care programs, the Florida Department of Health may collect your social security number for identification and billing purposes, as authorized by subsections 119.071(5)(a)2.a. and 119.071(5)(a)6., Florida Statutes. By signing below, I consent to the collection, use or disclosure of my social security number for identification and billing purposes only. It will not be used for any other purpose. I understand that the collection of social security numbers by the Florida Department of Health is imperative for the performance of duties and responsibilities as prescribed by law.

PART VI **MY SIGNATURE BELOW VERIFIES THE ABOVE INFORMATION AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS**

_____ _____ _____

Client/Representative Signature | Self or Representative's Relationship to Client | Date

_____ _____

Witness (optional) | Date

PART VII **WITHDRAWAL OF CONSENT**

I,_____WITHDRAW THIS CONSENT, effective _____

Client/Representative Signature | Date

For Office Use Only – Print or Use Label

Client Name: _____

MRN: _____

DOB: _____

DH 3204-SSG-02/2022