Fresno County Department of Public Health - Immunization Clinic
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

□ Check here if the responsible person is the patient.

☐ Parent ☐ Foster Parent* ☐ Minor is consenting *(limited services permitted unless emancipated*)*

☐ Legal Guardian* ☐ CAA (Caregiver Affidavit)* ☐ Notarized consent from parent* **Documentation 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/your child is eligible for VFC/317, and unable to provide payment for services today, you will NOT be turned away. Please speak with the receptionist.

Private Insurance (All ages)

☐ **Private** insurance

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.

VFC Eligibility (18 years old and under)

Please check all that apply:

☐ **Medi-Cal** or Child Health & Disability Program (CHDP)

☐ **Uninsured** (does not have health insurance)

☐ **American Indian or Alaskan Native**

317 Eligibility (19 years old and up)

Please check all that apply:

☐ **Uninsured** (does not have health insurance)

☐ **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.

Medi-Cal or Medicare (19 years old and up)

Please check all that apply:

☐ **Medi-Cal**

☐ **Medicare****

**Medicare clients must complete additional eligibility screening form.

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

Vaccine Funding Source *(select all that apply)*

□ VFC* □ 317 □ State □ Private

Form of Payment/Insurance *(select all that apply)*

□ Medi-Cal
□ Medicare (**copy of card attached to ensure name is exact match for billing purposes**)
□ Cash
□ Credit Card
□ Check
□ Fee Reduction (**form attached**)
□ Fee Waiver (**form attached**)

**If patient is underinsured and qualifies for VFC, FCDPH is not permitted to vaccinate these children per VFC guidelines. They must be referred to an FQHC or RHC for services.*