Carroll County Health Department Consent Form for Infant/Child Immunization

All services provided on a non-discriminatory basis.

Last Name	First Name	MI	DCN/SSN	Date of Birth / /	☐ Male ☐ Female
Street Address	City	State	Zip Code	Phone#	Check all that apply ☐ Medicaid ☐ Uninsured ☐ Private Insurance

Race (select all that apply): ☐Amer Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or other Pacific Islander ☐ Bi Racial or Multi Racial

Ethnicity: ☐ Non-Hispanic or Latino ☐ Hispanic or Latino

If you have **private insurance**, does it pay for immunizations? ☐ Yes ☐ No ☐ Don't Know

If Yes, please complete the following

Primary Insurance Name_____________________Member ID#________________GroupID#________________

Relationship to Insured____________ Insured First Name_______________Insured Last Name______________

Insured Date Of Birth ___/___/___ Insured Gender- F / M

*I give the Carroll County Health Department permission to share the above named child's medical record with the above insurance company for billing purposes.

Signature of person authorized to make the request_____________________________________Date___/___/___

	YES	NO	Don't Know
1. Is the child sick today?	☐	☐	☐
2. Does the child have allergies to medications, food(eggs), a vaccine component or latex?	☐	☐	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Has the child had a health problem with lung, heart, kidney or metabolic disease, asthma, or a blood disorder? Is he/she on long term aspirin therapy?	☐	☐	☐
5. Has the child, a sibling, or a parent had seizure?	☐	☐	☐
6. Has the child had brain or other nervous system problems(Guillian –Barre Syndrome)?	☐	☐	☐
7. Does the child have cancer, leukemia, AIDS or any other immune system problem?	☐	☐	☐
8. In the past 3 months, has the child taken cortisone, prednisone, other steroids, anticancer drugs, or had radiation treatments?	☐	☐	☐
9. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
10. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐	☐
11. Has the child received vaccinations in the past 4 weeks?	☐	☐	☐
12. Will this child be visiting someone, within the next 7 days, who requires a protected environment?	☐	☐	☐

Child's Doctor_________________________ Child's weight_______________

*I have been given a copy and have read, or had explained to me the information in the "Vaccine Information Statement(s),"where applicable, for the vaccine(s) indicated below. I have had a chance to ask questions and had them answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) currently due for which I have signed below be given to me or to the person named above for whom I am authorized pursuant to Section 431.058,RSMo to make this request.

*I authorize the release of the above named child's complete medical record, as it is available to the Carroll County Health Department, to those entities who request it with a legitimate cause for use of this information; including but not limited to: educational institutions, childcare facilities, employer and physicians' offices. I hereby release the Carroll County Health Department and its employees there in from any liability for releasing such information pursuant to this authorization.

X____________________________/______________________/________________/__________

Signature of person authorized to make the request / Print / Relationship to above / Date

FOR CLINIC USE ONLY- TO BE FILLED IN BY NURSING STAFF						
☐ First Vaccines	11/5/15	☐ DTaP/DT	5/17/07	☐ Tdap	2/24/15	
☐ Rotavirus	4/15/15	☐ Polio	7/20/16	☐ MCV4/MPSV4	3/31/16	
☐ MMR	4/20/12	☐ Hib	4/2/15	☐ MenB	8/14/15	
☐ Chickenpox	3/13/08	☐ PCV 13	11/5/15	☐ HPV -Gardasil 9	3/31/16	Temperature ______ ☐ N/A
☐ Hep A	7/20/16	☐ MMRV	5/21/10	☐ Shingles	10/6/09	☐ No immunization record
☐ Hep B	7/20/16	☐ Td	2/24/15	☐ Influenza		☐ Refused VIS forms

Appropriate VIS forms offered ☐

Signatures on consent form ☐

Discussed immunization(s) and possible side effects ☐

Notified to wait 10 minutes after injection(s) ☐

Nurse's Signature/Title____ Date_____/_____/_____

Rvs: 7/16cam