Immunizations Consent Form

Student Name _____ Date of Birth _____ Today's Date _____

IMMUNIZATION HEALTH QUESTIONNAIRE

1. Has the student been sick recently?	Yes	No	Don't Know
2. Does the student have allergies to medications, food or any vaccine? (eggs, yeast, jello, etc.)	Yes	No	Don't Know
3. Has the student had a serious reaction to a vaccine in the past?	Yes	No	Don't Know
4. Has the student had a seizure, brain or other nervous system problem?	Yes	No	Don't Know
5. Does the student have cancer, leukemia, AIDS or any other immune system problem?	Yes	No	Don't Know
6. Does the student take cortisone, prednisone, other steroids, or anticancer drugs, or had X-ray treatments in the past 3 months?	Yes	No	Don't Know
7. Has the student received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year?	Yes	No	Don't Know
8. Is the student pregnant or is there a chance she could become pregnant during the next month?	Yes	No	Don't Know
9. Has the student received any vaccinations in the past 4 weeks?	Yes	No	Don't Know

I have been given a copy and have read, or have had explained to me, the information contained on the appropriate Vaccine Information Statement (VIS) about the disease(s) and the vaccine(s) which are to be administered today. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the specific vaccine(s). I ask that the vaccine(s) I have requested be given to me or the person named above for whom I am authorized to make this request. I have been given a copy of or have had the opportunity to review the CCPHD Privacy Notice and may have a copy on request.

(**Student Name**) _____has my permission to receive the following immunizations:
(Please circle what immunizations you would like given.)

Tdap/Dtap (Tetanus, Diphtheria, Pertussis/Tetanus Booster) Meningococcal (Meningitis) Hepatitis B Series

MMR Series (Measles, Mumps, Rubella) HPV (Human Papillomavirus/Gardasil) Series Hepatitis A Series

Varicella Series (Chickenpox) Polio Series Influenza (Flu) PCV13 (Pneumococcal Conjugate)

I Decline the following Immunizations:_____
(Please List)

My child's health care provider has explained to me (and I understand) the following: The purpose of the recommended vaccination The risks and benefits of the recommended vaccination Possible consequence(s) of not allowing my child to receive the recommended vaccination may include contracting the illness the vaccine is intended to prevent and transmitting the disease to others My doctor, the American Academy of Pediatrics, the American Academy of Family Physicians, and the Centers for Disease Control and Prevention (CDC) have all strongly recommended that the vaccine(s) be given.

The health care provider has answered all of my questions.

I know that I may change my mind and accept vaccination for my child in the future.

I accept sole responsibility for any consequences as a result of my child not being vaccinated.

I acknowledge that I have read this document in its entirety and fully understand it.

_____ Date _____

Parent/Guardian/Student (if over 18) Signature (in Black Ink-No pencil)

Working to enhance our community's total well-being by promoting healthy life styles, protecting health, and preventing disease

IMMUNIZATION INSURANCE FORM

(Please circle yes or no for each question)

1. Does the person being vaccinated have MEDICAID insurance? Yes No

2. Is the person being vaccinated American Indian or Alaskan Native? Yes No

3. Does the person being vaccinated have private health insurance? Yes No
   (Example: Blue Cross, Travelers)

4. Does the private insurance pay any portion of the cost of vaccine? Yes No

Commercial Insurance Info: *Copy of Insurance Card if possible*

Insured Cardholder:

Name:
Birthdate:
Relationship to Patient:
Employer:
Policy #:
Contract #:
Group#:

Authorize insurance benefits to be paid directly to CCPHD, authorize the release of pertinent medical information to insurance carrier(s) to the extent permitted by law and agree to pay non-covered services.

Authorize all immunization information to be submitted to the Michigan Immunization Registry where you will be able to obtain immunization status through a medical provider. (Upon receipt of a written request from an individual who is 20 years of age or older, the department shall make any immunization information in the registry pertaining to that individual inaccessible.)

_____ Date _____

Parent/Guardian/Student Signature (in Black Ink-no pencil)

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