OTTAWA COUNTY DEPARTMENT OF PUBLIC HEALTH
AUTHORIZATION FOR NON-PARENT/NON-GUARDIAN
CONSENT FOR IMMUNIZATIONS

I hereby consent for my child ____

to be immunized by the Ottawa County Department of Public Health. I also authorize

____ to

accompany my child for such immunizations and to sign the immunization card for me. I have been given a copy and have read or have had explained to me the information contained in the VACCINE INFORMATION STATEMENT about the disease (s) and the vaccine (s) that are to be administered. I have read and completed the SCREENING QUESTIONNAIRE FOR CHILD AND TEEN IMMUNIZATION form on the reverse side of this consent form. I have had a chance to ask questions by calling the Ottawa County Department of Public Health. I believe I understand the benefits and risks of the specific vaccines (s). I ask that the vaccine (s) I have requested be given to the person named above for whom I am authorized to make this request and I ask that the administration of the vaccine (s) be recorded on the Immunization signature record card.

This consent form should be signed and dated and the screening questionnaire completed within 24 hours prior to your child receiving the vaccine (s).

____ ___________________
Parent/Legal Guardian Signature Date

If you have any questions or concerns, please call:
Ottawa County Department of Public Health
(616) 396-5266

Patient Name:_______________________________________ Date of birth: ______/______/______
Month Day Year

Screening Checklist for Contraindications to Vaccines for Children and Teens

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

Question	Yes	No	N/A
1. Is the child sick today?	☐	☐	☐
2. Does the child have allergies to medications, food, 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 (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	☐	☐	☐
5. If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐	☐	☐
6. If your child is a baby, have you ever been told that he or she has had intussusception?	☐	☐	☐
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐	☐	☐
8. Does the child have cancer, leukemia, AIDS, or any other immune system problem?	☐	☐	☐
9. In the past 3 months, has the child taken medications that weaken their immune system, such as cortisone, prednisone, other steroids or anticancer drugs; drugs for the treatment of rheumatoid arthritis Crohn's disease or psoriasis; or had radiation treatments?	☐	☐	☐
10. 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?	☐	☐	☐
11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐	☐
12. Has the child received vaccinations in the past 4 weeks?	☐	☐	☐

Parent/guardian signature: ________________________________ Date: ____________

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For clinic use only:

DTaP ____________	LAIV4____________	PTC____________
HAP ____________	MCV4____________	PVH ____________
HBY ____________	MMR____________	RV5 ____________
HIB ____________	MMRV____________	Td ____________
HPV9____________	MPSV4____________	Tdap____________
IIV4 ____________	PCV13____________	VAR____________
IPV____________	PPSV23____________	Other____________
KIN ____________	PRX ____________	Other____________