



Putnam County Health Department
Immunization Consent Form

Name of CHILD to be immunized: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Please Print the Child's Name

Parent/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Please Print Your Name

Your Address: \_\_\_\_\_

Street Apartment # Town State Zip Code

Physician Name: \_\_\_\_\_

Person who has permission to have my child immunized: \_\_\_\_\_

(Please Print)

Insurance Information: (Please check appropriate choice)

- My child is not insured
My child has Insurance or Medicaid (circle type) (Bring insurance card or copy of card)

I am the parent/guardian of the child listed above. I give permission to the person listed to have my child immunized and confirm that this person is familiar with my child's medical history. I give them the authority to make decisions about the required and recommended vaccination to be provided to my child at this visit only. I have instructed them to contact me if they have questions or concerns about the vaccines to be administered after reading the Vaccine Information Statements provided by the Health Department. I will not hold the Putnam County Health Department responsible for any decisions made by the person bringing my child for immunizations.

\_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature

Has the child to be immunized and listed above:

- 1. Been ill with a fever in the last 24 hours? No Yes
2. Ever had an allergy to eggs, vaccines, or any medications? No Yes
3. Ever had a serious reaction to a vaccine in the past? No Yes
4. Had a seizure (self, parent, sibling) or a neurological problem? No Yes
5. Have cancer, HIV, AIDS, or a suppressed immune system? No Yes
6. Take cortisone, prednisone or other steroids, respigam, chemotherapy or x-ray treatments? No Yes
7. Received a transfusion of blood, plasma, or a medicine called immune globulin in the past year? No Yes
8. Had a vaccine in the past 4 weeks? No Yes
9. Have lung, heart, kidney, liver, diabetes, asthma or blood disorder? No Yes
10. For females over the age of 10, is there a chance the child could be pregnant? No Yes N/A

I have answered the above questions to the best of my knowledge. I also grant permission for this record to be released to providers, health departments, schools, day care centers, WIC, and community and state immunization registry database.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_