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)

- o My child is not insured
- o 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_____

Official PCHD Form/Title: Immunization consent form with no parent
Created 6/25/18, Updated 5/18/2023
Location: Nursing drive, Nursing folder, Clinic stuff