



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: _____

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** (check 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 _____