Darke County General Health District

Immunization Screening & Consent Form

Patient Name: _____ _____
Last Name First Name M.I. Birth date

Check ALL that applies:

Medicaid health insurance ( ) WIC Eligible ( ) No Health Insurance ( )
Health Insurance ( ) Does your health insurance cover vaccines? Yes ( ) No ( )

Private Insurance: Anthem ( ) Medical Mutual ( ) United Health Care ( )
Other _____

Medicaid: Caresource ( ) Molina ( ) Ohio Medicaid ( )

Records of immunizations given by this health department are sometimes release to other entities in an effort to immunize your child according to schedule and comply with State Immunization reporting. Possible entities requesting information:

Parent, Relative, or Guardian	**Schools/Preschool**	**WIC**
Head Start or Day Care	**Other Health Departments**	**Job & Family Services**
Physicians/Hospitals	**Ohio Dept of Health**	**Help Me Grow**

- I acknowledge receiving the Darke County General Health Districts Notice of Privacy Practices
- I understand how health information may be used or disclosed.
- I understand a postcard may be sent or phone call to remind me of vaccinations due.
- I grant permission to the Darke County General Health District to give the requested vaccinations to myself or the person named or who I am authorized to make this request (as Parent/Guardian). I have received the vaccine information statements for the vaccines requested and have had the opportunity to ask questions concerning the vaccines to be given.

(This consent remains in effect until cancelled by parent or guardian)

I hereby choose NOT to allow my child to receive the following vaccine(s) from the Darke County General Health District. I have read the important information forms. I understand the benefits of the vaccines and the risks to my child if disease does occur. I do not hold the Darke County General Health District responsible for not giving the recommended vaccines. NOT receiving these vaccines may exclude my child from school/Head Start/Day Care should an outbreak of these diseases occur in the community.

_____ Vaccine _____ Date

Screening Questionnaire

For Parents/Guardians: The following questions will help us determine which vaccines you or your child may be given today. If you answer "yes" to any questions, it does not necessarily mean you or 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.

Please answer the following questions:	Yes	No	Don't Know
1. Is the person to be vaccinated sick today or on any medications currently?			
2. Are there any allergies to medications, food, a vaccine component, or latex?			
3. Has there ever been a serious reaction after receiving a vaccination?			
4. Is there 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 person to be vaccinated is between the ages of 2 and 4 years, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?			
6. If the person to be vaccinated is a baby, have you ever been told he or she has had intussusceptions?			
7. Has there been a seizure, brain, or other nervous system problem in any immediate family member? (patient, parent, sibling)			
8. Is there any cancer leukemia, AIDS, or any other immune system problem?			
9. Has there been cortisone, prednisone, steroids, anticancer drugs, or had radiation treatments in the past 3 months?			
10. In the past year, has there been a blood transfusion, blood products, immune (gamma) globulin or an antiviral drug?			
11. For Females: is there a chance of pregnancy now or during the next month?			
12. Has the person to be vaccinated received any vaccinations in the past 4 weeks?			
13. Has the person to be vaccinated ever had the chickenpox?			
14. Did you bring your immunizations record card with you? It is important to have a personal record of your vaccinations. Keep this record in a safe place and bring it with you every time you seek medical care. Vaccination records will be needed to enter day care or school, for employment, College, or for international travel.			

X (Patient/Guardian) Print Name: _____

X _____ _____

(Patient/Guardian) – Sign Name Date

Nurse Reviewing Form: _____