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 ☐ No Health Insurance ☐ Private Health Insurance ☐
Does your health insurance cover vaccines? Yes ☐ No ☐

Private Insurance: Anthem ☐ Medical Mutual ☐ United Health Care ☐
Other _____

Medicaid: Caresource ☐ Molina ☐ Ohio Medicaid ☐ Amerihealth Caritas ☐ Buckeye Health ☐
Humana Healthy Horizons ☐ United Health Community Plan ☐

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 grant permission to the Darke County General Health District (DCGHD) 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.
- I understand the DCGHD may send an appointment reminder or recall by mail/telephone/answering machine/email or text. Information is uploaded or directly entered into Ohio Immunization Information System (ImpactSIIS). Pre-appointment reminder or missed appointment recall notifications may come from ODH, ImpactSIIS or an affiliated public health organization. Screening data may be entered into ImpactSIIS.
- I or my designee will be given the vaccine information sheets for each vaccine given or recommended and will be given the opportunity to address any concerns. I understand the benefits/risks associated with the vaccines to be given. I am aware of the Vaccine Adverse Event Reporting System (VAERS).

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

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**	**Unsure**
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Are there any allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Has there ever been a serious reaction (anaphylaxis) after receiving a vaccination or history of Guillain-Barre syndrome?	☐	☐	☐
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/bowel obstruction?	☐	☐	☐
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; drugs for the treatment of RA, Crohn's or Psoriasis?	☐	☐	☐
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. Vaccines Not Given Today. **Declination of Vaccines** 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. _____			

To ensure the safety of all patients and staff, we enforce a Zero Tolerance Policy for disruptive or aggressive behavior during vaccinations. This includes flailing, screaming, refusal to cooperate, or any threatening actions. Patients may be asked to leave and return later. Children must be accompanied by a calm, supportive adult.

X (Patient/Guardian) **Print Name**: _____

X (Patient/Guardian) – **Sign Name** _____ **X Date**: _____

Nurse Reviewing Form: _____

Revised 7/31/2025