CHIRP #_____ Entered By_____

Immunization Clinic Consent Form

A. INFORMATION ABOUT PERSON RECEIVING VACCINE (PLEASE PRINT)

Name Last _____ First _____ Middle _____ Birth Date _____/_____/_____

Age _____ Gender *Male* *Female* Address _____

City _____ Zip Code _____ Phone Number_____

Parent/Guardian's Name (*if patient is younger than 18*) Last _____ First _____

Relationship _____ Phone Number _____

B. VACCINE ELIGIBILITY SCREENING (PLEASE CHECK APPROPRIATE OPTION)

_____ **Medicaid-eligible**

_____ **American Indian/Alaskan Native**

_____ **No Health Insurance**

_____ **Insurance Does Not Cover Vaccines (Underinsured)** A patient who has commercial (private) health insurance but the coverage does not include vaccines, patients whose insurance covers only selected vaccines (these patients are categorized as underinsured for non-covered vaccines only), or children whose insurance caps vaccine coverage at a certain amount (once that coverage amount is reached, these children are categorized as underinsured).

_____ **Covered by Health Insurance That Covers Vaccines** (Please Provide Insurance Card)

If your child is 12 months through 6 years of age, has he/she been tested for lead in the past 12 months? YES NO

C. ACKNOWLEDGMENT OF RECEIPT OF THE ST. JOSEPH COUNTY DEPARTMENT OF HEALTH NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been given an opportunity to read the Notice of Privacy Practices for the St. Joseph County Department of Health, and to have any questions answered before signing.

Patient or Parent/Guardian Signature:_____ Date:_____

St. Joseph County Department of Health Employee Signature: _____ Date: _____

D. VACCINE HEALTH SCREENING

Yes No 1. Is the patient sick today?

Yes No 2. Does the patient have any allergies to medication, food, a vaccine component, or latex?

Yes No 3. Has the patient ever had a serious reaction after receiving a vaccination?

Yes No 4. Does the patient have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g. diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Is the patient on long-term aspirin therapy?

Yes No 5. If the patient to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?

Yes No 6. If the patient is a baby, have you ever been told that he or she has had intussusception?

Yes No 7. Has the patient, a sibling, or a parent had a seizure, brain or other nervous system problem, including Guillain-Barré Syndrome?

Yes No 8. Does the patient, a sibling, or a parent have cancer, leukemia, HIV/AIDS, or any other immune system problem?

Yes No 9. In the past 3 months, has the patient taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease or psoriasis; or had radiation treatments?

Yes No 10. In the past year, has the patient received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?

Yes No 11. Is the patient pregnant or is there a chance she could become pregnant during the next month?

Yes No 12. Has the patient received vaccinations in the past 4 weeks? *If yes, please list vaccines* _____

FORM COMPLETED BY_____ DATE_____

FORM REVIEWED BY_____ DATE_____

E. CONSENT TO VACCINATE

I have read or had explained to me the information in the "Vaccine Information Statement(s)" or the "Important Information Statement(s)" for the disease(s) and vaccine(s) indicated below. I have had a chance to ask questions and fully understand the benefits and risks of the vaccine(s) indicated below. I request that these vaccines be given to me or to the person named above.

Indicated Vaccines:_____

Patient or Parent/Guardian Signature: _____ Date:_____