NCDHD North Central District Health Department

Vaccination Consent Form – Child (Birth – 18)

Follow-Up: | | | |

LAST NAME	FIRST NAME	MIDDLE INITIAL
AGE / BIRTHDATE		GENDER (circle) Male/Female
STREET ADDRESS	MAILING ADDRESS (IF DIFFERENT)	
CITY / STATE / ZIP		PHONE #

MOTHER'S MAIDEN NAME (First and Last):	Primary language, if other than English:	ETHNICITY	☐ Not Hispanic or Latino ☐ Hispanic or Latino
RACE	☐ White ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Other:		

1.	For children ages 6 months through 8 years receiving the flu shot: is this their first flu shot?	NA	YES	NO
2.	Is the child sick today?		YES	NO
3.	Does the child have allergies to medications, gelatin, yeast, eggs, latex or any vaccine?		YES	NO
4.	Has the child ever had a serious reaction to a vaccine in the past?		YES	NO
5.	Has the child had a seizure or a neurological problem?		YES	NO
6.	Does the child have cancer, leukemia, AIDS or any other immune system problem?		YES	NO
7.	Does the child take cortisone, prednisone, other steroids, anticancer drugs or X-Ray treatment?		YES	NO
8.	Has the child received a transfusion of blood or blood products or been given immune (gamma) globulin or an antiviral drug in the past 6 months?		YES	NO
9.	Is the child pregnant or is there a chance she could become pregnant during the next 3 months?		YES	NO
10.	Has the child had chicken pox?		YES	NO
11.	Has the child ever had Guillian-Barre syndrome?		YES	NO
11.	Has the child received vaccinations in the past 4 weeks?		YES	NO

INSURANCE QUESTIONS:

Is the child enrolled in Medicaid? YES NO	**Is the child American Indian or Alaskan Native? YES NO**
Is the child covered by health insurance? YES NO	**Is the child underinsured (has insurance but it does not pay for vaccines)? YES NO**

I GIVE CONSENT to North Central District Health Department and its staff to vaccinate the person listed on this form. I have received and read or had explained to me the Vaccine Information Statement(s) and understand the risks and benefits. I also acknowledge that North Central District Health Department has made their Notice of Privacy available for review. I understand that I may request a copy of the Notice of Privacy. I hereby grant permission to North Central District Health Department to release any pertinent information to the insurance carrier listed on the reverse side upon request and any physicians to whom I might be referred. If not eligible for Vaccines for Children Program (VFC) or Adult Immunization Program (AIP), I understand that I am responsible for charges not paid by my insurance company.

Parent/Guardian Signature:	Date:

WE REQUEST THAT YOU STAY ON SITE FOR 10 MINUTES AFTER RECEIVING YOUR VACCINATION(S). IF YOU CHOOSE TO LEAVE, YOU ASSUME ALL RESPONSIBILITY/LIABILITY FOR ANY ADVERSE EVENT. THANK YOU.

ADMINISTRATIVE USE ONLY

CHECK VACCINES TO BE RECEIVED:

☐ **Influenza**	☐ **Hep B**	☐ **Rotavirus**	☐ **DTaP**	☐ **Hib**	☐ **PCV13**	☐ **MMR**
☐ **Varicella**	☐ **Hep A**	☐ **MCV4**	☐ **Tdap**	☐ **HPV**	☐ **PCV23**	☐ **IPV**

Vaccine Name	Manufacturer	Lot Number	Expiration Date	Date Given	Site	
	GSK Merck Sanofi Pasteur				RA	LA
					RT	LT
Nurse Signature:						

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CLINIC SITE:	NESIIS Entry Date:	Billed Date:
	NESIIS Entry Initials:	Billed Initials:

Payment Information (check all that apply):			
☐ Cash	**For insurance, including Medicaid or Medicare, fill out information to right:**	Insurance Company:	☐ BCBS ☐ Cov ☐ MC ☐ UHC ☐ Mcaid ☐ Mcare ☐ Other
☐ Check		Primary Policyholder	
☐ Donation		Relationship to Insured	☐ Self ☐ Spouse ☐ Parent
☐ VFC		Policy/Member #	
☐ AIP		Group #	
☐ Insurance		Payer ID	
☐ Bill to:			