Williams County Health District

Williams County Health District Third Party Immunization Consent Form

Purpose: to enable the parent to authorize the provision of immunization for their child while under the supervision of the undersigned caregiver.

Name of CHILD to be immunized:____ Date of Birth:_______________
Please Print **Child's** Name

Parent/Guardian Name:____ Phone: _________________________
Please Print **Your** Name

Your Address:____
Street Apt # Town State Zip Code

Person who has permission to have my child immunized (Caregiver): ________________________________
Please Print

Insurance Information: Please check appropriate choices

- ○ My Child is **not** insured
- ○ My child **has insurance or Medicaid** (circle type)
  - Name of Insurance:____
  - Member's Name:_________________________ Policy #___________________ Group#_____________

The following questionnaire will help us determine which vaccines may be given. If you answer "yes" to any questions, it does not necessarily mean your child should not be vaccinated. It just means that additional questions must be asked.

Has the child to be immunized and listed above:

1. Is the child sick today?.. No___ Yes___
2. Does the child have allergies to medications, food, a vaccine component, or latex? .... No___ Yes___
3. Has the child had a serious reaction to a vaccine in the past? .... No___ Yes___
4. Does the child have a long-term health problem with lung. heart, 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 he/she on long-term aspirin therapy? .... No___ Yes___
5. If the child to be vaccinated is 2 through 4 years of age, has a health care provider told you that the child had wheezing or asthma in the past 12 months?........ No___ Yes___
6. If your child is a baby, have you ever been told he or she has had intussusception? .... No___ Yes___
7. Has the child, a sibling, or a parent had a seizure; has the child had a brain or other nervous system problems? .... No___ Yes___
8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem? .... No___ Yes___
9. Does the child have a parent, brother, or sister with an immune system problem? .... No___ Yes___
10. In the past 3 months, has the child 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? .... No___ Yes___
11. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?........ No___ Yes___
12. Female only: Is the child/teen pregnant or is there a change she could become pregnant during the next month?........ No___ Yes___
13. Has the child received vaccinations in the past 4 weeks? .... No___ Yes___

I have answered the above questions to the best of my knowledge. I also grant the permission for this record to be released to providers, health departments, schools, day-care centers, WIC, and community and state immunization registry database.

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. This caregiver is knowledgeable of my child and I give them consent to sign the Immunization Consent Form at time of service. They are capable of completing and answering any questions from the above Immunization Screening Questionnaire. I will not hold the Williams County Health Department responsible for any decisions made by the person bringing my child for immunizations.

____ Date____________________
Parent/Guardian **Signature**

____ Date____________________
Caregiver **Signature**