Williams County Health Department

Immunization Consent Form

Patient's Name	Date of Birth	Age	Male or Female
Address	City/State	Zip	
Phone	Family Doctor		

The following questions will help us determine which vaccines you 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 that additional questions must be asked. If a question is not clear, please ask the nurse to explain it.

	Yes	No	Don't Know
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Does the person to be vaccinated have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Does the person to be vaccinated have a long term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia, or other blood disorders?	☐	☐	☐
5. Does the person to be vaccinated have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
6. In the past 3 months, has the person to be vaccinated taken any medications that affect their immune system, such as prednisone, other steriods, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis, or had radiation treatments?	☐	☐	☐
7. Has the person to be vaccinated had a seizure or a brain or other nervous system problem?	☐	☐	☐
8. During the past year, has the person to be vaccinated received a blood transfusion or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
9. For women: Is the person to be vaccinated pregnant or is there a chance that they could become pregnant during the next month?	☐	☐	☐
10. Has the person to be vaccinated received any vaccinations in the past 3 months?	☐	☐	☐
11. If the person to be vaccinated is a baby, have they ever had intussusception?	☐	☐	☐

I have received a copy and have read or have had read to me and explained the information contained in the Vaccine Information Statement. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request. By signing this consent, I authorize the use and/or disclosure of my health information for treatment, payment, or health care operations. I have the right not to sign this consent; however, if I refuse to sign this consent, the health department has the right to refuse treatment to me. My rights include (1) to receive a paper copy of the Notice of Privacy Practices prior to signing consent, (2) to request restrictions on the uses and disclosures of health information, (3) the right to revoke the consent at anytime except to the extent that the health department has already taken certain actions based on the consent prior to revoking it, (4) the right to receive a copy of this consent form after it is signed. I also request payment of government benefits and/or health insurance to the Williams County Health Department. This consent is effective unless and until I revoke it in writing.

X

Signature of Patient (Parent or Guardian) Date

Williams County Health Department

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Patient Name DOB Age VFC PRIVATE UNINSURED

Vaccine	Dose #	Date Given	MFG/Lot #	Injection Site	Stated Side Effects. Given VIS		Administered by
Pediarix						multivaccine 11/5/15	
DTaP						5/17/2007	
Kinrix						Dtap 5/17/07 IPV 7/20/2016	
Tdap						2/24/2015	
Hib						4/2/2015	
IPV						7/20/2016	
RV4 Rota						2/23/2018	
PCV 13						11/5/2015	
PPSV23						4/24/2015	
HepB ped						7/20/2016	
HepB adult						7/20/2016	
HepA ped						7/20/2016	
HepA adult						7/20/2016	
Twinrix						7/20/2016	
MMR						2/12/2018	
Varicella						2/12/2018	
MMRV						2/12/2018	
9vHPV						12/2/2016	
MCV4						3/31/2016	
MenB						8/9/2016	
Zoster						2/12/2018	

Recall:

Revised 7/11/2018