District Health Department #10
Healthy People, Healthy Communities

Personal Health Division

Serving Crawford, Kalkaska, Lake, Manistee, Mason, Mecosta, Missaukee, Newaygo, Oceana, and Wexford Counties

Vaccine Administration Consent – *Absent Parent/Guardian*

Please read the attached Vaccine Information Statements, and provide ALL requested information on the FRONT and BACK of this form. Please send insurance card with the child.

If you have any questions about vaccines, insurance, or administration fees, please call Central Scheduling toll free at ***1-888-217-3904 (press #2.)***

Registration Information

Child's Name		Date of Birth / /	
Parent/Guardian Name		Phone	
Child Address			
City	State	Zip	
Child's Insurance		Household Size	
Member ID#	Group#	Household Income	
Subscriber Name		Date of Birth / /	
Subscriber Social Security #		Phone	
Subscriber Address *(if different)*			
City	State	Zip	

Race
- ☐ Am Indian/ Alaskan Native
- ☐ Arabic
- ☐ Asian
- ☐ Black/African Am
- ☐ Native Hawaiian/ Pacific Islander
- ☐ White
- ☐ Other

Ethnicity
- ☐ Hispanic/Latino
- ☐ Non-Hispanic/Latino

Language
- ☐ English
- ☐ Spanish
- ☐ Other_____
- ☐ Translation Needed

Current Health – *please mark a box Yes or No for each question about the child's health*

1.	Is the child sick today?	☐ Yes ☐ No
2.	Does the child have allergies to medications, food, a vaccine component, or latex?	☐ Yes ☐ No
3.	Has the child had a serious reaction to a vaccine in the past?	☐ Yes ☐ No
4.	Has the child had a health problem with lung, heart, kidney, or metabolic disease (like diabetes), asthma, or a blood disorder? Is the child on long-term aspirin therapy?	☐ Yes ☐ No
5.	For children 2-4 years old, has the child had wheezing or asthma in the past 12 months?	☐ Yes ☐ No
6.	If the child is a baby, have you ever been told he/she had intussusception?	☐ Yes ☐ No
7.	Has the child, a sibling, or a parent had a seizure? Does the child have brain or other nervous system problems?	☐ Yes ☐ No
8.	Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐ Yes ☐ No
9.	In the past 3 months, has the child taken medications that affect the immune system such as prednisone or other steroids; drugs to treat cancer, Crohn's disease, arthritis, or psoriasis; or had radiation treatments?	☐ Yes ☐ No
10.	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?	☐ Yes ☐ No
11.	Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐ Yes ☐ No
12.	Has the child received vaccinations in the past 4 weeks?	☐ Yes ☐ No

Recommended Vaccines

The vaccines checked below are currently recommended for your child. *Please review the provided Vaccine Information Statements closely. Please mark the box for either Accept or Decline for each vaccine recommended. Marking "Accept" means you wish your child to receive the indicated vaccine at his/her appointment.*

Recommended	*I choose to:*	
☐ Diphtheria, tetanus, acellular pertussis (DTaP)	☐ Accept	☐ Decline
☐ Diphtheria, tetanus (DT or Td)	☐ Accept	☐ Decline
☐ Haemophilus influenzae type B (Hib)	☐ Accept	☐ Decline
☐ Hepatitis A	☐ Accept	☐ Decline
☐ Hepatitis B	☐ Accept	☐ Decline
☐ Human Papillomavirus (HPV)	☐ Accept	☐ Decline
☐ Influenza (flu)	☐ Accept	☐ Decline
☐ Measles, mumps, rubella (MMR)	☐ Accept	☐ Decline
☐ Meningococcal (MenACWY or MenB)	☐ Accept	☐ Decline
☐ Pneumococcal vaccine (PCV13 or PPSV23)	☐ Accept	☐ Decline
☐ Polio (IPV)	☐ Accept	☐ Decline
☐ Rotavirus	☐ Accept	☐ Decline
☐ Tetanus, diphtheria, acellular pertussis (Tdap)	☐ Accept	☐ Decline
☐ Varicella (chickenpox)	☐ Accept	☐ Decline

Authorization and Signature

Parent/Guardian *- please read and complete*

I give my permission to District Health Department #10 to release my medical information to my medical insurance provider as required for billing purposes. I acknowledge that I have been offered a copy of the District Health Department #10 Notice of Privacy Practices.

I understand that if my child's immunization services are not a covered insurance benefit, my child may be eligible for the Vaccines for Children Program (VFC) and will only be billed the administration fee. If my child's insurance is out-of-network for DHD#10, or if I have not met the deductible and/or co-pays, I will be billed for the cost of the immunization(s) and/or administration fees as directed by the State of Michigan.

I have been given a copy and have read, or have had explained to me, the information contained on the appropriate Vaccine Information Statements (VIS) about the vaccines to be administered to my child and the diseases to be prevented. I have had a chance to ask questions that were answered to my satisfaction.

I understand the benefits and risks of immunizations, and I ask that the immunization services be provided to my child and recorded in the DHD#10 Electronic Health Record.

I, _____, give permission to _____
(parent name printed) *(18 years or older)*

to bring my child, _____, to receive the vaccines as indicated above from

District Health Department #10 on _____.
(appointment date)

_____ _____
Parent/Guardian Signature *Date*