GALLIA COUNTY GENERAL HEALTH DISTRICT
499 Jackson Pike, Suite D, Gallipolis, OH 45631
Gerald E. Vallee, M.D., Health Commissioner

INFANT-CHILD-ADOLESCENT IMMUNIZATION CONSENT FORM

Child's Name: (Last)_____(First)_____(MI)_____Race:_____ Sex: M or F

Birthdate:____/____/____ Age:_____Child's SS#____/____/____ Telephone#_____

Address: (Street)_____(City)_____(State)_____(Zip)_____

Mother's Name _____Mother's SS# ____/____/____Father's Name _____

PLEASE ANSWER THE FOLLOWING QUESTIONS

1. Does the child have (please check): _____ Private Insurance _____ Insurance does not cover vaccine's _____ No insurance
_____Medicaid _____ United Healthcare Comm Plan _____ Molina _____ Caresource

	Yes	No	Explain
2. Does your child have a blood clotting disorder such as hemophilia or thrombocytopenia, or take anticoagulants (blood thinners)?	☐	☐	_____
3. Are you the birth parent, adopted parent, or legal guardian?	☐	☐	_____
4. Is your child a WIC client?	☐	☐	_____
5. Is the child well today?	☐	☐	_____
6. Does the child have any allergies to medications, food, or any other vaccine?	☐	☐	_____
7. Has the child taken any medications in the past 24 hours?	☐	☐	_____
8. Does the child, you or anyone who takes care of your child presently have a serious illness such as cancer, HIV/AIDS, leukemia, a blood disorder, or take cortisone, chemotherapy or radiation therapy?	☐	☐	_____
9. Has the child ever had any severe reaction to previous immunizations? Including fever higher than 104 degrees, prolonged crying or screaming? Seizures, etc?	☐	☐	_____
10. Has the child had a blood transfusion, gamma globulin injection or any other vaccination in the past 3 months?	☐	☐	_____
11. Has the child ever had Guillain Barre' Syndrome?	☐	☐	_____
12. For adolescent female clients requesting MMR or Menactra: Are you pregnant? You should not become pregnant for three months after receiving MMR or Menactra vaccine.	☐	☐	_____
13. For adolescent female clients requesting Varicella Vaccine: Are you pregnant? You must wait until after you have given birth before getting the vaccine. You should not get pregnant for 1 month after getting the vaccine.	☐	☐	_____

I have read or have had explained to me the Vaccine Information Statement for the vaccines my child is to receive today. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccines and request that it be given to the child named above for whom I am authorized to make this request. I also authorize the release of immunization information to other health care agencies and schools at the discretion of the Health Department staff. I authorize the Health Department to bill for my (or my child's) service today. The presence of my signature certifies that I have received information on the HIPAA Privacy Notice.

_____ _____
Signature of Client / Authorized Guardian Date

Gallia County Health Department operates in accordance with Title VI of the Civil Rights Act of 1964

OFFICE USE ONLY: REFERRED TO WIC: YES NO REFERRED FROM WIC: YES NO INITIALS:_____