Wayne County Healthy Communities
Childhood Immunization Consent Form

Name of child: _____
Last First MI Date of Birth Sex Age

Parent/Guardian Name: _____
Last First MI

_____
Street Address City State Zip Phone #

1. Has the Child had a serious reaction to an immunization in the past? Yes / No
   If Yes-- explain: _____.
2. Does the Child have an allergy to eggs, yeast, antibiotics or other medications? Yes / No
   If Yes – explain _____.
3. Has the child ever had a seizure, a neurologic or other serious medical problem? Yes / No
   If Yes – explain: _____.
4. Does your child or anyone who lives with the child/takes care of the child have cancer, leukemia, AIDS or any other immune system problem? Yes / No
   If Yes – explain: _____.
5. Has the child received a transfusion of blood, plasma, or immune globulin in the past 3 months? Yes / No
   If Yes – explain: _____.
6. Has the child been ill within the last 24 hours? Yes / No
   If Yes – explain: _____.
7. Has the Child taken any medication in the past 48 hours? Yes / No
   If Yes – Explain: _____.
8. Has the child taken steroids or other medications that could affect their immune system in the past 3 months? Yes /No
   If yes – explain _____.
9. If female, is your child pregnant? Yes / No
10. Does your child see a doctor regularly for check ups? Yes / No
    If Yes, Doctor's name: _____.
    Address: _____
11. Please circle eligibility for this service:
    - No medical insurance for child
    - American Indian/Alaska Native
    - Child covered by Medicaid
    - Child's medical insurance does NOT cover immunizations

Before signing this form I read the information (VIS form) about the immunization(s) my child will be receiving. I understand: 1) The reason they are getting the immunization; 2) the ways the immunization could help my child; 3) the most important kinds of risks and discomforts that the immunization could cause my child; and 4) other kinds of care my child might have if s/he does not get the immunization. I know there may be other risks if my child gets the immunizations, which are believed small, are not expected, or are not known. No one has given me a promise or guarantee of what will happen if my child receives the immunization. All my questions about the immunization have been answered. I understand that my child's immunization information will be entered in to Michigan's Childhood immunization registry. By signing this form I am confirming that my child has no insurance coverage for immunizations, is not insured, or that my child has Medicaid or MI Child coverage.

_____ _____
Signature (**Circle One**) Mother / Father / Guardian Date

WAYNE COUNTY HEALTHY COMMUNITIES
"A Federally Qualified Health Center"

2013 - INFLUENZA VACCINE CLINIC (INACTIVATED – The Flu Shot)

INFORMED CONSENT – 2013-2014

Last _____ First _____ Date of Birth _____

Address _____ City_____ State___ ZIP_____
Phone _____

Please answer the following questions and check the appropriate column	Yes	No
o Are you pregnant?		
o Are you sick or do you a have a fever today?		
o Have you ever had a life-threatening allergic reaction after a dose of seasonal flu vaccine?		
o Have you ever had a serious reaction to influenza vaccine in the past?		
o Have you had any other vaccines within the past month?		
o Are you allergic to eggs or to a component of the vaccine?		
o Do you have a history of Guillain Barre'?		
o Have you read the Inactivated Influenza Vaccine Information Statement Sheet?		

I have read or have had read to me the information statement about the Inactivated Influenza Vaccine
I have had a chance to ask questions, which were answered to my satisfaction. I understand the benefits and the risks of the influenza vaccine and request that it be given to me or the person named above for whom I am authorized to make this request.

Signature _____ Date _____

For clinical use only. Do not write below this line.

Dose
6-35 months - 0.25 ml
3 yrs and older - 0.5 ml

Injection Site
___Right arm ___Right thigh
___Left arm ___Left thigh

Manufacturer _____

Lot Number _____

Expiration Date _____

Date _____

Time _____ a.m./ p.m.

By _____
Signature

Information on consent form (reverse side of form) reviewed by/date: _____

Comments/notes (if applicable):

_____

_____

Immunization	Series #	Site/Route	Manufacturer	Lot #	Exp. Date	VIS Date
DTaP	1 2 3 4 5					
Td	1 2					
Hib	1 2 3 4					
Hep B	1 2 3 4					
IPV	1 2 3 4 5					
MMR	1 2					
PCV7	1 2 3 4					
Varicella	1 2					
Meningococcal	1 2					

_____ _____

Nurse's Signature Date Imm/VIS given