FIN #: _____ VFC: Y N office use only

CHILD IMMUNIZATION CONSENT FORM

All information collected on this form is strictly confidential and will become part of your medical record.

Child Name:	**Birth Date:**	**Age:**
Parent/Guardian Name:		**Sex: M ☐ F ☐**
Address:	**City/State:**	**Zip Code:**
Phone #:	**Alternate Phone #:**	

Insurance Information & VFC Eligibility Screening

Name of Insurance: ☐ Healthy MT Kids *Plus* ☐ Healthy MT Kids *Basic (CHIP)* ☐ Other (specify): _____

Please check which pertains to your child (if any):

- ☐ Does not have health insurance
- ☐ Health insurance does *not* include vaccines - ***underinsured***
- ☐ Health insurance only covers select vaccines (list vaccines: _____) - ***underinsured***
- ☐ Child's vaccine coverage is capped at a certain amount *(amount of cap: $_____) – **underinsured***
- ☐ Child is American Indian or Alaskan Native

Screening

The following questions help us determine which vaccines your child may receive. If you answer "yes" to any question it does not necessarily mean your child should not receive a vaccine, it just means additional questions may be asked.

Is your child sick today? Y N

Does your child have any of the following? If yes, please circle:
Asthma Leukemia Lung/heart/kidney disease HIV/AIDS Cancer Diabetes or other metabolic disease
Blood disorder Liver disease Any other immune system disorders

Does your child have allergies to foods, medications, latex or had a serious reaction to past vaccines? Y N
If yes, please describe: _____

Has the child, a sibling or a parent ever had a seizure or other nervous system problem? Y N

In the past 3 months has your child taken prednisone/other steroids/anticancer drugs, or had radiation treatments? Y N

In the past 3 months has your child received a blood transfusion or been given immune (gamma) globulin or an antiviral drug? Y N

Has your child received any immunizations in the past 4 weeks? Y N
If yes, please list: _____

Is your child/teen pregnant or is there a chance she could become pregnant in the next month? Y N

If your child is a baby, have you ever been told he or she has had intussusception? Y N

The following information will be used for statistical reports only.	
What is the child's race? (circle all that apply) White Native American/Alaska Native Asian Black/African American Native Hawaiian/Pacific Islander Other	
Is the child of Hispanic or Latino origin? Y ☐ N ☐	**If the child is female is she currently pregnant?** Y ☐ N ☐
Does the child have any special health care needs (congenital/chronic medical conditions)? Y ☐ N ☐	

Your child is due for the following vaccines:

Single Vaccines
☐ DTaP; TDaP *(tetanus, diphtheria, pertussis)*
☐ Haemophilus *(ActHib)*
☐ IPV *(polio)*
☐ MMR *(measles, mumps, rubella)*
☐ Varicella *(chickenpox)*
☐ Hepatitis A
☐ Hepatitis B
☐ Gardasil *(HPV)*
☐ Meningococcal *(meningitis)*
☐ Pneumococcal *(Prevnar 13)*
☐ Rotavirus *(Rotateq)*

Combination Vaccines
☐ Kinrix *(DTaP & polio)*
☐ Pediatrix *(DTaP, hepatitis B, & polio)*
☐ Proquad *(MMR & Varicella)*

I have read the Vaccine Information Sheet(s) and have had a chance to ask questions. The risks and benefits have been explained to me. My signature below indicates that I consent to the vaccine(s) to be given to me or the person named above for whom I am authorized to make this request. I give this consent without coercion or reservation.

X_____ X_____

Parent/Guardian Signature *Date*

I authorize Roundup Memorial Healthcare Clinic to collect and enter my child's immunization records into the Department of Public Health and Human Services Immunization Registry (ImMTrax). ImMTrax is a confidential, computer system that contains immunization records. I understand that information in the registry may be released to a public health agency as well as my healthcare providers to assist in my child's medical care. In addition, information may be released to child care facilities and schools in which my child is enrolled to comply with state immunization requirements. I understand that I can revoke this authorization and have my record removed at any time by contacting my local health department.

The above information is true to the best of my knowledge.

X_____ X_____

Parent/Guardian Signature *Date*