

# SPECIAL EVENT IMMUNIZATION CONSENT FORM

Student's Name Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M or F

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Message: \_\_\_\_\_

Parent/Legal Guardian's Name: \_\_\_\_\_ Mother's Maiden Name \_\_\_\_\_

School Name: \_\_\_\_\_ Grade \_\_\_\_\_

**Ethnicity** Hispanic / Not Hispanic / Unknown      **Race** White / American Indian / Black / Alaskan Native / Asian / Hawaiian—Pac Islander / Other

**Circle all that apply** \*Ages 0-18 yrs only\*

Medicaid / No Insurance / Insurance / American Indian / Alaskan Native

**Medicaid Information**

Name (as printed on card): \_\_\_\_\_ Medicaid# \_\_\_\_\_

**Primary Insurance**

Patient's relationship to insured: Self Spouse Child

Insurance Company: \_\_\_\_\_ Name of Primary Insured: \_\_\_\_\_

Primary Insured's Date of Birth: \_\_\_\_\_ Insured Phone: \_\_\_\_\_

ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's address if different from above: \_\_\_\_\_

**PLEASE READ AND INITIAL:**

\_\_\_\_\_ Central District Health Department will bill your health insurance or Medicaid.

\_\_\_\_\_ IF YOU DO NOT have insurance you will be billed directly for the administration fee(s).

\_\_\_\_\_ I need financial assistance. My household size \_\_\_\_\_ My monthly Income \_\_\_\_\_

\_\_\_\_\_ I acknowledge that I was given a copy, and I have read the Central District Health Department Notice of Privacy Practices and Financial Policy (see attached)

For billing questions please call our Finance Department at 327-8594.

**FOR OFFICE USE ONLY**

Payment Category: \_\_\_\_\_

Staff initials: \_\_\_\_\_

Insurance

Medicaid

Other

**PLEASE COMPLETE OTHER SIDE.**

**Child will not be vaccinated, if back side is not completed**

**The following questions will help us determine which vaccines you may be given today. Please circle YES or NO**

|   |     |    |
|---|-----|----|
| Is the patient sick today?  | YES | NO |
| Does the patient have any known allergies to medications, food, vaccine component or latex? (For example: eggs) Please list: _____  | YES | NO |
| Has the patient ever had a serious reaction after receiving a vaccine? (Routine or Flu vaccines)  | YES | NO |
| Has the patient ever had Guillain-Barre Syndrome (a type of temporary, severe muscle weakness), seizures or neurological disorders?   | YES | NO |
| Does the patient have cancer, leukemia, HIV/AIDS, immune system problems, or have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)? | YES | NO |
| Does the patient take cortisone, prednisone, other steroids, or anti-cancer drugs, or has the patient had radiation treatments? Long term aspirin therapy? Daily aspirin dose _____.  | YES | NO |
| During the <b>past year</b> , has the patient received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin? If yes, when? month _____ day _____                                 | YES | NO |
| Has the patient received a MMR, Varicella, FluMist, or Yellow Fever vaccine in the <b>past four weeks</b> ? If yes, when: month _____ day _____   | YES | NO |
| Does the patient have any of the following: asthma, wheezing, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?  | YES | NO |
| Has the patient had chickenpox? If yes, when? _____   | YES | NO |
| <b>For females:</b> Are you pregnant or is there a chance you could become pregnant during the next month?  | YES | NO |

**ALL CLIENTS: PLEASE READ THE FOLLOWING, INITIAL, SIGN AND DATE**

\_\_\_\_\_ Participation in and withdrawal from the Immunization Registry (IRIS) is voluntary. Call Idaho Immunization Program at 208-334-5931 to opt-out or withdraw. If you do not opt-out of IRIS in writing, your child's immunization records will be stored in the registry.

\_\_\_\_\_ I GIVE CONSENT to the Central District Health Department and its staff for my child named on the front of this form to be vaccinated for ACIP recommended vaccines.

\_\_\_\_\_ I don't want my child to have the following vaccines: \_\_\_\_\_

**If this consent form is not signed, dated, and returned, then your child will not be vaccinated**

**Client/Guardian Signature:** \_\_\_\_\_ **Relationship to Child:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**(FOR NURSES USE ONLY)**

**(FOR NURSES USE ONLY)**

**(FOR NURSES USE ONLY)**

**(FOR NURSES USE ONLY)**

**Nurse signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_