IONIA COUNTY HEALTH DEPARTMENT CONSENT TO IMMUNIZE IN EVENT OF ABSENT PARENT

PLEASE PRINT

If you are having someone else bring your child(ren) in please have this form **filled out completely**. The form is be filled out by the parent. On the second page please check all of the health concerns that need to be addressed before vaccines are given. This form needs to be filled out **each and every** time someone brings the child(ren) in to be seen.

Name of Parent: _____Phone # _____Address_____

Medicaid Yes or No Medicaid #_____ Medicaid Health Plan _____ _____
We accept Medicaid and any Medicaid Health Plans (McLaren, Meridian, Molina, Priority Health, Blue Cross Complete, United Healthcare)

Other Insurance Information:

Insurance _____**Policy #** _____**Group #**_____
We accept Blue Cross Blue Shield, Blue Care Network or Priority Health **PLEASE SEND COPY OF INSURANCE CARD**

Policy Holder's Name and Birthdate: _____

Name of Person Bringing Child(ren) (must be 18 years or older) _____Relationship_____
Person bringing them in must have ID on them

Please fill out appropriate box with the child's name and put a check mark in the box below that child's name for the vaccines you are wanting them to receive. Immunization records will be reviewed at the time of service for each child. We will give the recommended vaccines at the time of visit unless you specify differently. If there is a recommend vaccine that you do not want them to receive, please write refuse in the appropriate box next to that vaccine. At end of visit they will be given an updated immunization record.

	Child's Name	Child's Name	Child's Name	Child's Name	Child's Name	Child's Name
Vaccine Name						
Dtap						
Hib						
Polio						
Rotavirus						
Hep A						
Hep B						
MMR						
Varicella						
MMRV						
PCV13						
Seasonal Influenza						
Pneumococcal						
Tdap						
HPV						
Men-ACWY						
Men B						
Sars-Cov-2						

_____ _____ _____

Parent's Name **(print)** Parent's Signature Date Signed

THIS PAGE MUST BE COMPLETED BY PARENT

Health History of child(ren) (if child has been ill with a fever in the last two days please delay vaccines until fever has been gone for 2 days with no mediations.) Please answer the following questions in the boxes below for child(ren).

1. Any allergies to food, medications, latex or vaccines. If so what they are and the reactions.
2. Any serious reactions to a vaccine in the past? **Yes** or **No**
3. Any Seizure of brain problems? **Yes** or **No**
4. Any health problems with heart, lung, kidney or blood disorder. **Yes** or **No**
5. Any long term steroid use, aspirin or aspirin containing products, anticancer drugs or had x-ray treatments in the last past 3 months? **Yes** or **No**
6. Any blood transfusion of blood or blood products or been given a medicine call immune (gamma) globulin the past year. **Yes** or **No**
7. Any vaccines given in the last 4 weeks? **Yes** or **No**

	Child's Name	Child's Name	Child's Name	Child's Name	Child's Name	Child's Name
Question 1						
Question 2						
Question 3						
Question 4						
Question 5						
Question 6						
Question 7						

_____ _____ _____

Parents Name for Medical History (**print**) Parents Signature for Medical History Date

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