Seneca County General Health District, 92 E. Perry St., Tiffin, 419-447-3691

Immunization Consent Form for Children ages Birth to 18 years

I, ____________________________________ the undersigned parent, legal guardian, or person having legal custody of ___________________________________ do hereby authorize ____________________________________ to represent me as Guardian and provide consent to the appropriate licensed health care provider of the Seneca County General Health District (SCGHD) to proceed with the administration of the appropriate vaccines based on age and the schedule recommended by the Center for Disease Control and Prevention (CDC) for my child, a minor, noted above.

It is mandatory that you send the child's shot record and current health insurance card along to the appointment.

CHILD'S DATE OF BIRTH _______________________________

		Yes	No	N/A
1	Is the child sick today?	☐	☐	
2	Does the child have allergies to medications, food, a vaccine component (gelatin), or latex?	☐	☐	
3	Has the child had a serious reaction to a vaccine in the past?	☐	☐	
4	Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	☐	☐	
5	If your child is a baby, have you ever been told he or she has had intussusception?	☐	☐	☐
6	Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐	☐	
7	Does the child or family member have cancer, leukemia, AIDS, or any other immune system problems?	☐	☐	
8	In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease or psoriasis; or had radiation treatments?	☐	☐	
9	In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	
10	FEMALES: Is the child/teen pregnant or is there a chance she could become pregnant in the next month?	☐	☐	☐
11	If your child is between the age 1 to 6, has he/she been tested for lead poisoning with the past year?	☐	☐	☐
12	Has the child received any vaccines in the past 4 weeks?	☐	☐	

I have received a copy or had one made available to me through the Seneca County General Health District's web site and have read, or had read to me, the information contained in the appropriate Vaccine Information Statement (V.I.S.) about the disease(s) and vaccines(s) that my dependent will receive. I believe I understand the benefits and risks of the vaccine(s) to be received. (V.I.S. forms are located at https://www.cdc.gov/vaccines/hcp/vis/current-vis.html) I have had a chance to ask questions, (by calling the Seneca County General Health District office) which were answered to my satisfaction. I understand the required vaccine information for my dependent is being sent to a central registry at the Ohio Department of Health.

Parent, Guardian and Adults signatures are in recognition and acceptance of the content of this page

Parent/Guardian Signature: ____ **Date** _____/_____/______

Home telephone: __________________________ **Other telephone I may be reached at:** _________________________

Adult bringing child to clinic Signature: ____ **Date** _____/_____/______

Seneca County General Health District
92 E. Perry St. Tiffin, Ohio 44883
CONSENT FOR SERVICES

By my signature below,

1. I consent to the administration of vaccine(s) by an RN at SCGHD who has determined, based on Center for Disease Control's (CDC) Recommended Immunization Schedule and a current vaccine record provided by the client/guardian.
2. I understand that:
   - I have voluntarily chosen to receive the vaccination and understand that I am obligated to pay for all products and services received, if applicable.
   - I may be responsible for payment after the date of service if the product or service is billed to my medical benefit.
   - I am responsible for all co-pays, amounts to be applied to deductibles and other amounts that may be stated to be my responsibility by the insurance carrier.
   - It is my responsibility to know what services are/are not covered under my health insurance plan.
   - I am of legal age and authorized to execute this consent form or I am the parent/guardian of the minor patient.
   - I will alert SCGHD of any medical conditions which may adversely affect my personal health or effectiveness of the vaccine.
   - I have been counseled about potential side effects after vaccination, when they may occur, and when and where I should seek treatment. I am responsible for following up with my physician at my expense if I experience any side effects.
   - I will alert SCGHD of potential side effects for reporting to Vaccine Adverse Event Reporting System (VAERS) and documenting in my medical record.
   - I may be requested to remain in the area for observation after vaccination(s). If I leave the area without waiting, I acknowledge that I am doing so at my own risk and against the advice of the professional who administered the vaccine(s).
   - I have read, or have had read to me, the Vaccine Information Statement(s) ("VIS") or Emergency Use Authorization ("EUA") provided for the vaccine(s) to be administered. I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccine(s).
   - I have been offered and/or provided a copy of SCGHD's Notice of Privacy Practices in compliance with the Health Insurance Portability and Accountability Act (HIPAA).
   - Vaccination(s) are subject to reporting by SCGHD to the Ohio ImpactSIIS (an immunization registry maintained by the Ohio Department of Health), which may share my immunization data with others, including but not limited, to my primary care physician, the authorizing physician, and the local Department of Health, and I authorize these disclosures.
3. I release SCGHD and its subsidiaries, affiliates, officers, directors, employees, and agents from all liability, including acts of omission or commission, resulting, or arising from my receipt of this vaccination.

X____

Signature of Patient or Parent/Guardian of Minor Patient   Date