



Immunization Screening & Consent Form

Child /Self _____
 Last Name First Name M.I. Birthdate

Records of immunizations given by the Mercer County – Celina City Health Department are sometimes released to other entities in an effort to immunize your child according to recommended dosing and scheduling and to comply with State Immunization reporting. Possible entities requesting information:

- | | |
|-------------------------------|----------------------|
| Parent, Relative, or Guardian | Schools/Preschool |
| Head Start or Day Care | WIC |
| Physicians | Hospitals |
| Job & Family Services | Help Me Grow |
| Other Health Departments | Ohio Dept. of Health |

- I acknowledge that I have received the Mercer County – Celina City Health Department Notice of Privacy Practices.
- I understand the above statement on how health information may be used or disclosed.
- I understand an appointment reminder may be sent by mail or telephone call/answering machine.
- I grant permission for the Mercer County – Celina City Health Department to immunize my child in my absence when brought to the clinic by my designee (i e, grandparent, babysitter)
- I grant permission to the Mercer County – Celina City Health Department to immunize my adolescent/teen less than 18 years of age when he/she comes unaccompanied by a parent or legal guardian. I understand an attempt will be made to contact me if a problem arises. I understand another appointment will be made in lieu of giving vaccines if the problem cannot be resolved.
- I grant permission to the Mercer County- Celina City Health Department to give the requested vaccination/s to myself or the person named above for whom I am authorized to make this request (as Parent or Guardian). I have received the vaccine information Statements for the vaccine/s requested and have had the opportunity to ask questions concerning the vaccines to be given.

Signature _____ **Date** _____

This form remains in effect until cancelled by parent or guardian

The following questions will help us determine which vaccines you or your child may be given today. If you answer "yes" to any question, it does not mean you should not be vaccinated. It just means additional questions may be asked.

Please answer the following questions:	Yes	No	Don't Know
1. Is the person to be vaccinated sick today?			
2. Are there any allergies to medications, food, or any vaccine			
3. Has there ever been a serious reaction after receiving a vaccination			
4. Is there a health problem with: heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, a blood disorder, or are you taking blood thinners ?			
5. Is there any cancer, leukemia, AIDS, or any other immune system problem?			
6. Has cortisone, prednisone, other steroids, anticancer drugs, or any x-ray treatments in the past 3 months?			
7. Has there been a seizure, brain, or other nervous system problem?			
8. If the child to be vaccinated is between the ages of 2 and 4 years, has a Healthcare provider told you that the child had wheezing or asthma in the past 12 months?			
9. Has there been a blood transfusion, blood products or immune (gamma) globulin given in the past year?			
10. For females: Is there any chance of pregnancy, or becoming pregnant during the next month?			
11. Have you received any vaccinations in the past 4 weeks?			

Form completed by: _____ Date: _____

Form reviewed by: _____ Date: _____

Did you bring your immunization record with you? **yes** **no**

It is important to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one with all your child's vaccinations on it. Keep this record in a safe place. This record will be needed for school entry or daycare, for employment, or for international travel.