



FULTON COUNTY HEALTH DEPARTMENT IMMUNIZATION CONSENT FORM

Name of CHILD to be immunized: _____ Date of Birth: _____
Please Print the Child's Name

Parent / Guardian Name: _____ Phone: _____
Please Print Your Name

Your Address: _____
Street Apartment # Town State Zip Code

Person who has permission to bring my child for immunization(s): _____
(Please Print)

Insurance Information: (Please check appropriate choice)
 My child is not insured My child has Insurance* **or** **Medicaid*** (circle type) * copy of card is required

Child listed above:

1. Have you been ill with a fever in the last 24 hours? No Yes
2. Ever had a serious allergy to eggs, a vaccine component, latex rubber or any medications? No Yes
3. Have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g. diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? No Yes
4. Ever had a seizure or a neurological problem? No Yes
5. Do you currently have HIV, AIDS, or a suppressed immune system? No Yes
6. Take cortisone, prednisone, other steroids, chemotherapy or x-ray treatments at this time? No Yes
7. Received a transfusion of blood, plasma, or a medicine called immune globulin in the past year? No Yes
8. Received any other vaccination in the past 4 weeks? No Yes
9. For females over the age of 10, is there a chance that you could be pregnant or become pregnant in the next month? N/A No Yes
10. If under age 9, have you had a flu shot in the past? N/A No Yes

Consent for Vaccination Services

Initial I have answered the screening questions to the best of my knowledge. I have **received a copy of the appropriate Vaccine Information Statements (VIS) about the vaccines to be given today.** I have read the VIS or had it explained to me. I have had a chance to ask benefits and risks of the vaccine(s). I am responsible for the cost of today's services that are not covered by insurance. I consent for the administration of the vaccine(s) indicated on this record be given to me or the person named for whom I am authorized to make this request.

Initial **Acknowledgement for use of photos/videos/commentary by the Fulton County Health Department.** I understand that only pictures taken on this date and taken with my consent will be used. I also understand that I will not be compensated for the use of any photos, videos, or commentary.

Signature: _____ Date _____ (see next page)



HIPAA Acknowledgement & Authorization

Initial _____ I understand as part of the health record, FCHD maintains a vaccination record. FCHD's **Notice of Privacy Practices** is posted and a copy will be provided to me at my request.

Initial _____ I **authorize the use and/or disclosure of my health information** for treatment, payment and health care operations. I also request payment of government benefits. I understand that I have no obligation to sign this authorization and that FCHD will not condition services based on the execution of this authorization. This authorization is in effect for a period of 5 years unless I revoke in writing. Standard coordination of care includes providing records to providers, health departments, schools, day-care centers, WIC, and state immunization registry databases.

I am the parent/guardian of the child listed above. **I give permission to the person listed above** to have my child immunized and confirm that this person is familiar with my child's medical history. I give them the authority to make decisions about the required and recommended vaccinations to be provided to my child **at this visit only**. I have instructed them to contact me if they have questions or concerns about the vaccines to be administered after reading the Vaccine Information Statements provided by the Health Department. I will not hold the Fulton County Health Department responsible for any decisions made by the person bringing my child for immunizations.

Parent /Guardian Signature _____ Date _____