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 have my child immunized: _____

(Please Print)

Insurance Information: (Please check appropriate choice)

- My child is not insured
- My child has **Insurance** **or** **Medicaid** (circle type)
  Name of Insurance Company_____
  Member's Name _____ Policy #: _____ Group # _____

I am the parent/guardian of the child listed above. I give permission to the person listed 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.

_____ Date _____

Parent/Guardian Signature

Has the child to be immunized and listed above:

1. Been ill with a fever in the last 24 hours? NO_____ YES_____
2. Ever had an allergy to eggs, vaccines, or any medications? NO_____ YES_____
3. Ever had a serious reaction to a vaccine in the past? NO_____ YES_____
4. Had a seizure or a neurological problem? NO_____ YES_____
5. Have cancer, HIV, AIDS, or a suppressed immune system? NO_____ YES_____
6. Take cortisone, prednisone other steroids, respigam, chemotherapy or x-ray treatments NO_____ YES_____
7. Received a transfusion of blood, plasma, or a medicine called immune globulin in the past year? NO_____ YES_____
8. For females over the age of 10, is there a chance the child could be pregnant? NO_____ YES_____ N/A ____
9. If under age 9, has the child had a flu shot in the past? NO_____ YES_____ N/A _____

I have answered the above questions to the best of my knowledge. I also grant permission for this record to be released to providers, health departments, schools, day-care centers, WIC, and community and state immunization registry database.

Parent /Guardian Signature_____ Date_____

Official FCHD Form/Title: immwebconsent **Created** 4/1/2011
Location: (FCHD Drive/Forms Folder/Immunization Folder)