GCGHD
GALLIA COUNTY GENERAL HEALTH DISTRICT
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HEALTH COMMISSIONER/MEDICAL DIRECTOR

Public Health
Prevent. Promote. Protect.
Gallia County
Health Department

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Infant-Child-Adolescent Immunization Consent Form

Child's Name: (Last)_____(First)_____(MI)_____Sex: M or F

Birthdate:_____Age:_____Race:_____Phone:_____S.S. #_____

Address:_____City:_____State:_____Zip_____

Mother's Name:_____Mother's S.S. #_____Father's Name:_____

□Private Insurance □Medicaid □Medicare □Insurance Does Not Cover Vaccines □No Insurance

PLEASE ANSWER THE FOLLOWING QUESTIONS	YES	NO	EXPLAIN
1. Does your child have a blood clotting disorder such as hemophilia or thrombocytopenia, or take anticoagulants (blood thinners)?			
2. Are you the birth parent, adopted parent, or legal guardian?			
3. Is the child a WIC client?			
4. Is the child well today?			
5. Does the child have allergies to medications, food, or any other vaccine?			
6. Has the child taken any medications in the past 24 hours?			
7. Does the child, you, or anyone who takes care of your child presently have a serious illness such as cancer, HIV/AIDS, leukemia, a blood disorder, or take cortisone, chemotherapy, or radiation therapy?			
8. Has the child ever had any severe reaction to previous immunizations? Including fever higher than 104 degrees, prolonged crying, or screaming? Seizures, etc.?			
9. Has the child had a blood transfusion, gamma globulin injection, or any other vaccination in the past 3 months?			
10. Has the child ever had Guillain Barre' Syndrome? (Condition in which immune system attacks nerves that can lead to paralysis starting in the feet and working up)			
11. For adolescent female clients requesting MMR or Menactra: Are you pregnant? (You should not become pregnant for three months after receiving a MMR or Menactra vaccine)			
12. For adolescent female clients requesting Varicella Vaccine: Are you pregnant? (You must wait until after you have given birth before getting the vaccine. You should not get pregnant for 1 month after getting the vaccine)			

I have read or have had explained to me the Vaccine Information Statement for the vaccines that my child is to receive today. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccines and request that it be given to the child named above for whom I am authorized to make this request. I also authorize the release of immunization information to other health care agencies, schools, and place of employment at the discretion of the Health Department staff. I authorize the Health Department to bill for my child's service today. The presence of my signature certifies that I have received information on the HIPAA Privacy Notice.

_____ _____

Signature of Client/Authorized Guardian Date

January 2019

Refusal to Vaccinate

Child's Name _____ Child's DOB _____

Parent's/Guardian's Name _____

My child's doctor/nurse, _____, has advised me that my child (named above) should receive the following vaccines:

Recommended	Declined
☐ Hepatitis B vaccine	☐
☐ Diphtheria, tetanus, acellular pertussis (DTaP or Tdap) vaccine	☐
☐ Diphtheria tetanus (DT or Td) vaccine	☐
☐ *Haemophilus influenzae* type b (Hib) vaccine	☐
☐ Pneumococcal conjugate or polysaccharide vaccine	☐
☐ Inactivated poliovirus (IPV) vaccine	☐
☐ Measles-mumps-rubella (MMR) vaccine	☐
☐ Varicella (chickenpox) vaccine	☐
☐ Influenza (flu) vaccine	☐
☐ Meningococcal conjugate or polysaccharide vaccine	☐
☐ Hepatitis A vaccine	☐
☐ Rotavirus vaccine	☐
☐ Human papillomavirus (HPV) vaccine	☐
☐ Other _____	☐

I have been provided with and given the opportunity to read each Vaccine Information Statement from the Centers for Disease Control and Prevention explaining the vaccine(s) and the disease(s) it prevents for each of the vaccine(s) checked as recommended and which I have declined, as indicated above. I have had the opportunity to discuss the recommendation and my refusal with my child's doctor or nurse, who has answered all of my questions about the recommended vaccine(s). A list of reasons for vaccinating, possible health consequences of non-vaccination, and possible side effects of each vaccine is available at www.cdc.gov/vaccines/pubs/vis/default.htm. I understand the following:

- The purpose of and the need for the recommended vaccine(s).
- The risks and benefits of the recommended vaccine(s).
- That some vaccine-preventable diseases are common in other countries and that my unvaccinated child could easily get one of these diseases while traveling or from a traveler.
- If my child does not receive the vaccine(s) according to the medically accepted schedule, the consequences may include
  - Contracting the illness the vaccine is designed to prevent (the outcomes of these illnesses may include one or more of the following: certain types of cancer, pneumonia, illness requiring hospitalization, death, brain damage, paralysis, meningitis, seizures, and deafness; other severe and permanent effects from these vaccine-preventable diseases are possible as well).
  - Transmitting the disease to others (including those too young to be vaccinated or those with immune problems), possibly requiring my child to stay out of child care or school and requiring someone to miss work to stay home with my child during disease outbreaks.
- My child's doctor and the American Academy of Pediatrics, the American Academy of Family Physicians, and the Centers for Disease Control and Prevention all strongly recommend that the vaccine(s) be given according to recommendations.

Nevertheless, I have decided at this time to decline or defer the vaccine(s) recommended for my child, as indicated above, by checking the appropriate box under the column titled "Declined." I know that failure to follow the recommendations about vaccination may endanger the health or life of my child and others with whom my child might come into contact. I therefore agree to tell all health care professionals in all settings what vaccines my child has not received because he or she may need to be isolated or may require immediate medical evaluation and tests that might not be necessary if my child had been vaccinated.

I know that I may readdress this issue with my child's doctor or nurse at any time and that I may change my mind and accept vaccination for my child any time in the future.

I acknowledge that I have read this document in its entirety and fully understand it.

I have had the opportunity to rediscuss my decision not to vaccinate my child and still decline the recommended immunizations.

Parent/Guardian Signature: _____ Date: _____

Witness: _____ Date: _____

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American Academy of Pediatrics
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