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

June 2024

Refusal of Recommended Immunizations

Child's Name _____ DOB _____

Parent's / Guardian's Name _____

My child's pediatrician or other health care provider, _____, has advised me that my child (named above) should receive each vaccine or immunization checked below:

Recommended today, *which prevents these serious complications:*	**Today I refused:** *Initials of Parent or Guardian*
☐ **COVID-19 vaccine** *Pneumonia, respiratory failure, blood clots, bleeding disorder, injury to liver, heart or kidney, multi-system inflammatory syndrome, post-COVID syndrome, death*	
☐ **Diphtheria, tetanus, acellular pertussis (DTaP or Tdap) vaccine** *Tetanus – broken bones, breathing difficulty, death; Diphtheria – swelling of the heart muscle, heart failure, coma, paralysis, death; Pertussis(whooping cough) – pneumonia, death*	
☐ **Haemophilus *influenzae* type B (Hib) vaccine** *Meningitis, intellectual disability, closing of the throat, pneumonia, death*	
☐ **Hepatitis A (HepA) vaccine** *Liver failure, joint pain, kidney, pancreatic and blood disorders, death*	
☐ **Hepatitis B (HepB) vaccine** *Chronic liver infection, liver failure, liver cancer, death*	
☐ **Human papillomavirus (HPV) vaccine** *Cervical, vaginal, vulvar, penile, anal, mouth and throat cancers*	
☐ **Influenza (flu) vaccine** *Pneumonia, bronchitis, sinus infections, ear infections, death*	
☐ **Measles, mumps, and rubella (MMR) vaccine** *Measles - brain swelling, pneumonia, death; Mumps - meningitis, brain swelling, swelling of testicles or ovaries, deafness, death; Rubella – miscarriage, stillbirth, premature delivery, birth defects*	
☐ **Meningococcal (circle: MenACWY / MenB / MenABCWY) vaccine** *Meningitis, infection of the bloodstream, blindness, deafness, loss of limbs, death*	
☐ **Pneumococcal (PCV) vaccine** *Blood infection, meningitis, death*	
☐ **Poliovirus (IPV) vaccine (inactivated)** *Paralysis, death*	
☐ **Respiratory syncytial virus (RSV) immunization** *Bronchiolitis, pneumonia, lung failure, death*	
☐ **Rotavirus (RV) vaccine** *Severe diarrhea, dehydration, death*	
☐ **Varicella Chickenpox (VAR) vaccine** *Infected blisters, bleeding disorders, brain swelling, pneumonia, death*	
☐ **Others (please list)** _____	

I have been given a Vaccine Information Statement from the Centers for Disease Control and Prevention that explains each immunization and the disease(s) it prevents. I have discussed the recommendation and my refusal with my child's pediatrician or other healthcare provider. They have answered all of my questions about the recommended immunizations. I know I can find more information at https://www.cdc.gov/vaccines/parents/FAQs.html.

I understand the following:

- The checked immunization(s) are recommended by my child's pediatrician or healthcare provider, the American Academy of Pediatrics, the American Academy of Family Physicians, and the Centers for Disease Control and Prevention.
- The benefits and risks of the recommended immunization(s) checked.
- If my child does not receive the immunization(s) according to the standard, evidence-based schedule, the consequences may include:
  - Contracting the illness the immunization is designed to prevent, which could lead to serious complications as listed in the table.
  - 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.
- Some immunization-preventable diseases are common in other countries. My unvaccinated child could get one of these diseases while traveling or from someone who traveled to another country.

Today, I refused the recommended immunization(s) for my child by initialing the box(es) in the column titled "Today I refused."

I agree to tell all health care professionals in all settings which immunization(s) my child has not received and if my child is under immunized, as my child may need to be isolated or may require immediate medical evaluation and tests that might not be necessary if my child had been immunized.

If you change your mind at any time, speak with your child's pediatrician or other health care provider. You can always accept immunization(s) for your child in the future.

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

Parent / Guardian Signature: _____ Date:

This form was adapted from the American Academy of Pediatrics Refusal of Recommended Immunizations Form, 2024