Warren County Health District
416 S. East Street Lebanon, Ohio 45036
Child Immunization To Be Given

***Child's Name_____D.O.B.____/____/_____Age____Sex M F**
Last First M.
***Parent or Guardian (print)_____Date_____**

***Address_____City_____Township_____**

Parent/Guardian complete 1st three lines, INITIAL BEFORE VACCINES YOU WANT GIVEN, answer questions, sign and date the bottom

BY SIGNING THIS FORM YOU ARE GIVING WARREN COUNTY HEALTH DISTRICT PERMISSION TO ADMINISTER ANY OF THE VACCINES INITIALED BELOW WITHOUT A PARENT AND/OR GUARDIAN PRESENT. When you sign the release for treatment you also acknowledge that you have been notified of Notice of Privacy Practice.

	DTAP,DT,TDAP,TD(age appropriate)		**Hepatitis A**		**Combination Vaccines:**
	IPV		**MMR**		**Vaxelis** (Dtap-HIB-IPV-HepB)
	Pneumococcal 15		**Varicella**		**Pentacel (**Dtap-HIB-IPV**)**
	HIB		**HPV 9**		**Pediarix (**Dtap-HepB-IPV**)**
	Hepatitis B		**Meningococcal**		**Quadracel (**Dtap-IPV**)**
	Rota Virus		**Meningococcal B**		**Proquad (**MMR-Varicella**)**

IS THE INDIVIDUAL THAT IS GOING TO RECEIVE VACCINE:

Ill with anything more serious than a cold?.....No__Yes__
Have any allergies? (i.e. eggs, medications, thimerosal, neomycin, baker's yeast, gelatin, polymycin, streptomycin, aluminum, phenoxethanzl, latex)……No__Yes__
Had a serious reaction to a vaccine in the past?..... No__Yes__
Has the child had a health problem with lung,heart,kidney or metabolic disease, asthma, or blood disorder? Is he/she on long-term aspirin therapy?.....No__Yes__
Received a transfusion of blood, plasma, or a medicine called immune globulin in the past year?.....No__Yes__
Had a seizure or neurological problem?.....No__Yes__
Currently nursing a baby?.....No__Yes__
Resides in a home with a newborn infant?..... No__Yes__
If your child is a baby, have you ever been told he/she has had intussesception?.....No__Yes__

DOES THE INDIVIDUAL AND/OR ANYONE LIVING WITH OR TAKING CARE OF THE INDIVIDUAL:

Have cancer, leukemia, AIDS, or any other immune system problem?..... No__Yes__
Has the child taken medications that weaken their immune system, such as cortisone, prednisone, steroids, anticancer drugs, or x-ray treatment in the past 3 months?.....No__Yes__
Pregnant or at risk of becoming pregnant within the next three (3) months?..... No__Yes__
Received any vaccinations in the past four (4) weeks?..... No__Yes__

INITIALS

I understand this record will be released to State Imm. Registry Database..... _____
I GRANT permission for this record to be released to Third Party Payor(s)?..... _____
I HAVE received information concerning "Notice of Privacy Practices"..... _____
I HAVE answered the above questions to the best of my knowledge.
I UNDERSTAND THE BENEFITS AND RISKS OF THE Vaccine(s) and give my consent that the vaccine(s) indicated on this form be given to me or the person named for whom I am authorized to make this request.

_____DATE_____
SIGNATURE OF PARENT/LEGAL GUARDIAN/CLIENT **INITIAL BEFORE VACCINES YOU WANT GIVEN**