Williams County Health Department

3rd Party Immunization Consent Form

Name of the Child: _____ Date of Birth: _____

Address: _____ Phone #: _____

Mother: _____ Father: _____

Address: _____ Address: _____

_____ _____

Phone #: _____ Phone #: _____

Caregiver: _____ Phone #: _____

I, the undersigned parent/guardian, acknowledge that I have been informed of the routine immunization schedule for children by the Williams County immunization staff. At this point in time, I elect to have this child, immunized against all communicable diseases, which he/she could be protected.

I hereby give permission to _____ to have my child immunized. The caregiver is familiar with this child's medical history. I give them the authority to make decisions about the required and recommended vaccinations that are provided to my child. 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. They are capable of completing and answering any questions from the attached Immunization Screening Questionnaire. This consent is effective until revoked in writing by either parent/guardian.

I grant the permission for this record to be released to providers, health departments, schools, day-care centers, WIC, and community and state immunization registry database. I will not hold the Williams County Health Department responsible for any decisions made by the person bringing my child for immunizations.

By Signing below, the undersigned has read all the terms of this form and understands that he/she is signing a complete release and bar to any claim resulting from having this child immunized, as described herein.

X _____ _____

Parent/Guardian Signature Date

X _____ _____

Caregiver Signature Date

Public Health
Prevent. Promote. Protect.
Williams County Health District

6/13/2023

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Please have the caregiver review this questionaire as they will be responsible for answering these questions at the time of the appointment.

	Yes	No	Don't Know
1. Is the child sick today?	☐	☐	☐
2. Is the child allergic to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Does the child have a long-term health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Is he/she on long-term aspirin therapy?	☐	☐	☐
5. If the child is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐	☐	☐
6. If your child is a baby, have you ever been told that they had intussusception?	☐	☐	☐
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐	☐	☐
8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
9. Does the child have a parent, brother, or sister with an immune system problem?	☐	☐	☐
10. In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, psoriasis; or had radiation?	☐	☐	☐
11. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
12. Is the child/teen pregnant or is there a change that she could become pregnant during the next month?	☐	☐	☐
13. Has the child received vaccinations in the past four weeks?	☐	☐	☐