OTTAWA COUNTY DEPARTMENT OF PUBLIC HEALTH
AUTHORIZATION FOR NON-PARENT/NON-GUARDIAN
CONSENT FOR IMMUNIZATIONS

I hereby consent for my child _____

to be immunized by the Ottawa County Department of Public Health. I also authorize

_____to

accompany my child for such immunizations and to sign the consent to treat and HIPAA documents.

I have read and completed the SCREENING CHECKLIST FOR CONTRAINDICATIONS TO VACCINES FOR CHILDREN & TEENS form on the reverse side of this consent form. I have had a chance to ask questions by calling the Ottawa County Department of Public Health. I ask that the vaccine (s) I have requested be given to the child/teen named above for whom I am authorized to make this request, and I believe I understand the benefits and risks of the specific vaccines (s) being given to my child. Vaccine Information Statements and other vaccine information will be provided at the time of appointment.

This consent form should be signed and dated, and the screening questionnaire completed within 24 hours prior to your child receiving the vaccine (s).

_____ _____
Parent/Legal Guardian Signature Date

If you have any questions or concerns, please call:
Ottawa County Department of Public Health
(616) 396-5266

Patient Name:_____ Date of Birth:_____/_____/_____
Month Day Year

Screening Checklist for Contraindications to Vaccines for Children & Teens

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	N/A
1. Is the child sick today?	☐	☐	☐
2. Does the child have allergies to medications, food, a vaccine component, or latex? Please list: _____	☐	☐	☐
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, sickle cell disease, complement component deficiency, or a cochlear implant? Is the child on long term aspirin therapy?			
5. If the child to be vaccinated 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 a spinal fluid leak, 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, anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	☐	☐	☐
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 chance they could become pregnant during the next month?	☐	☐	☐
13. Has the child received vaccinations in the past 4 weeks?	☐	☐	☐

Parent/Guardian Signature: _____ Date: _____

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For clinic use only:

DTaP _____
DTaP/IPV _____
DTaP/IPV/HepB_____
DTaP/IPV/HIB _____
HepA_____
Hep B_____
HIB_____
HPV9 _____

IIV4 _____
IPV _____
LAIV4_____
MenACYW_____
MenB _____
MMR _____
MMRV _____
PCV15 _____

PPSV23 _____
RV5 _____
Td _____
Tdap _____
VAR _____
COVID _____
Other_____
Other_____

Adapted from www.immunize.org Screening Checklist for Contraindications to Vaccines for Children and Teens 10/2020; Rev. 6.16.22; Rev. 6.21.23 TRB