

**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 immunization card for
me. I have been given a copy and have read or have had explained to me the information
contained in the VACCINE INFORMATION STATEMENT about the disease (s) and
the vaccine (s) that are to be administered. I have read and completed the SCREENING
QUESTIONNAIRE FOR CHILD AND TEEN IMMUNIZATION 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 believe I understand the benefits and risks of the
specific vaccines (s). I ask that the vaccine (s) I have requested be given to the person
named above for whom I am authorized to make this request and I ask that the
administration of the vaccine (s) be recorded on the Immunization signature record card.

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?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
2. Does the child have allergies to medications, food, a vaccine component, or latex? Please list: _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3. Has the child had a serious reaction to a vaccine in the past?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
4. Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
6. If your child is a baby, have you ever been told that he or she has had intussusception?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
8. Has the child had his/her spleen removed or have you been told that the child’s spleen is not working? Or does the child have sickle cell disease?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
9. Does the child, a sibling or a parent have cancer, leukemia, AIDS, or any other immune system problem?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
10. In the past 3 months, has the child taken medications that weaken their immune system, such as cortisone, prednisone, other steroids or anticancer drugs; drugs for the treatment of rheumatoid arthritis Crohn’s disease or psoriasis; or had radiation treatments?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
12. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
13. Has the child received vaccinations in the past 4 weeks?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Parent/guardian signature: _____ Date: _____

For clinic use only:

DTaP _____	IIV4 _____	PPSV23 _____
DTaP/IPV _____	IPV _____	RV5 _____
DTaP/IPV/HepB _____	LAIV4 _____	Td _____
DTaP/IPV/HIB _____	MenACYW _____	Tdap _____
HepA _____	MenB _____	VAR _____
Hep B _____	MMR _____	Other _____
HIB _____	MMRV _____	Other _____
HPV9 _____	PCV13 _____	Other _____