Child and Adolescent Immunization Questionnaire (0-18 years)

Dickinson-Iron District Health Department

Revised September 2023

Office staff will complete this section with you.		
	Does not have private health insurance (uninsured)	**VFC – Uninsured**
	Has health insurance, but it does not cover immunizations (under-insured)	**VFC – Underinsured**
	Enrolled on Medicaid	**VFC - Medicaid**
	Is an American or Alaskan Native	**VFC – American Indian/Alaskan Native**
	Has health insurance that covers all or part of the immunization fees	**Not VFC Eligible – Use Purchased Vaccines and these administration codes: Private insur. injection or Private Insur. Admin nasal/oral**

Child's/Teen's Name: _____ **Date of Birth**: _____ **Age**: _____

Please circle race: African American American Indian Alaskan Native Asian Vietnamese White Other: _____

Please circle ethnicity: Hispanic or Latino Not Hispanic or Latino Prefer not to answer

Circle approximate weight

Up to 10# 10-20# 21-31# 31-40# 41-50# 51-60# 61-80# 81-100# Over 100#

Questions about the child or adolescent	YES	NO	Don't Know
Is the child sick today?			
Does the child have allergies to medications, food, a vaccine component, or latex?			
Has the child had a serious reaction to a vaccine in the past?			
Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?			
If your child is a baby, have you ever been told he/she has had intussusception?			
In the past year, has the child received a transfusion of blood/blood products, or been given a medicine called immune (gamma) globulin, or an antiviral drug?			
Does the child, or any person who lives with or takes care of the child, have cancer, leukemia, HIV/AIDS, or any other immune system problem?			
In the past 3 months, has the child taken medications that weaken their immune system, such as cortisone, prednisone, other steroids, or anti-cancer drugs, or had radiation treatments?			
Is the child/teen pregnant or is there a chance she could become pregnant during the next mo.?			
If the child is between the ages of 2 and 4 years, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?			
Has the child had a health problem with lung, heart, kidney, or metabolic disease (i.e. diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?			
Does the child have close contact with a person who needs care in a protected environment? (ex: someone who has recently had a bone marrow transplant)			
In the last 4 weeks, has the child received any vaccines?			
Has the child had the chicken pox disease? If yes, approximately what date or age? _____			

I have been given a copy and have read, or have had explained to me, the information contained on the appropriate Vaccine Information Statement (VIS) about the disease(s) and the vaccine(s) which are to be administered today. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the specific vaccine(s) and I ask that the vaccine(s) listed above 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 in the MCIR.

I authorize the DIDHD to release all necessary information and records for the billing and receiving of payment for services received. I authorized and assign directly to the DIDHD any and all benefits I may be entitled to and are otherwise payable to me for these services. After payment is received from my insurance company, I understand I may be responsible for any balance on my account for which I will receive a statement. If however, I personally receive payment from my insurance company for these services, I will forward this payment to the DIDHD.

I acknowledge receipt of the DIDHD's Notice of Privacy Practices.

If you are not present with your child for this appt. you must indicate which vaccines you are consenting to. Call the Health Department if you have questions. I consent to these vaccines: _____

Parent/Guardian Signature (or Patient, if 18 years old): _____ **Date**: _____

Refusal to Consent to Vaccination Children and Adolescents

Place this in the patient's medical record and remember to document all vaccine refusals in the MCIR

Child's Name: _____ Date of Birth: _____

Parent's/Guardian's Name(s): _____

My child's health care provider has advised me that my child (named above) should receive the following vaccines:

Vaccine	GIVEN	REFUSED	Reason for Refusal
COVID			
Diphtheria, tetanus, acellular pertussis (DTaP)			
Diphtheria, tetanus (DT or Td)			
Haemophilus influenzae type B (Hib)			
Hepatitis A (Hep A)			
Hepatitis B (Hep B)			
Human papillomavirus (HPV)			
Influenza			
Measles, mumps, rubella (MMR)			
Meningococcal (MCV or MPSV)			
Meningococcal B			
Pneumococcal vaccine (PCV or PPSV)			
Polio (IPV)			
Rotavirus (RV)			
Tetanus, diphtheria, acellular pertussis (Tdap)			
Varicella (chickenpox) (Var)			
Other:_____			

I have read the Centers for Disease Control and Prevention's Vaccine Information Statement(s) explaining the vaccine(s) and the disease(s) they prevent. My child's health care provider has explained to me (and I understand) the following:

- The **purpose** of the recommended vaccination
- The **risks and benefits** of the recommended vaccination
- **Possible consequence(s)** of not allowing my child to receive the recommended vaccination may include contracting the illness the vaccine is intended to prevent and transmitting the disease to others
- My doctor, the American Academy of Pediatrics, the American Academy of Family Physicians, the Centers for Disease Control and Prevention, and the Michigan Department of Health and Human Services **strongly recommend** that the vaccine(s) be given.

The health care provider has answered all of my questions. I know that I may change my mind and accept vaccination for my child in the future.

I accept sole responsibility for any consequences as a result of my child not being vaccinated. I acknowledge that I have read this document in its entirety and fully understand it.

Parent/Guardian Signature Date Time

Witness Date Time

MDHHS
Michigan Department of Health & Human Services