Child and Adolescent Immunization Questionnaire **(0-18 years)**

Dickinson-Iron District Health Department

Revised June 2026

	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 □CHAMPS	**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**: _____

Race: □ African American □American Indian □Alaskan Native □Asian □Vietnamese □White □Other: _____
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?			

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 <u>not</u> present with your child for this appt. you must indicate which vaccine(s) you consent to.**

Call the Health Department with questions. I consent to these vaccines: _____

_____

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

MDHHS-6310, MICHIGAN CARE IMPROVEMENT REGISTRY (MCIR) IMMUNIZATION NOTICE

Michigan Department of Health and Human Services (MDHHS)
Division of Immunization
(Revised 3-26)

The Michigan Care Improvement Registry (MCIR) provides a place for your immunization history to be stored confidentially. MCIR is used as a tool and can help providers accurately determine if a vaccine is needed based on the recorded immunization history. MCIR collects and combines immunization information for Michigan residents of all ages. Information in MCIR is confidential and all MCIR users are held to strict security and confidentiality requirements.

Having immunization data in MCIR can:

- Prevent harmful delays in medical care.
- Prevent over or under vaccination for a person (i.e. missing a vaccine or getting a repeated dose).
- Reduce healthcare burden by providing an accurate immunization history for providers to base their recommendations.

You have the right to object to having your child's immunization(s) reported to MCIR, which is otherwise required by MCL 333.9209. Remember, if immunization information is not stored in MCIR, your provider might not have access to a complete immunization history, and it will be essential for you to keep your child's immunization record for future medical visits, schooling or possible employment opportunities.

An immunization history can be printed by a healthcare provider. For those 18 years or older, you can print your immunization record yourself from the secure MCIR Public Portal.

By signing this form, I acknowledge that I have received the form.

Signature	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 (Patient, if 18 years old): _____ **Date**:_____

Witness:_____ Date: _____ Time:_____

MDHHS
Michigan Department of Health & Human Services