FREMONT COUNTY DEPARTMENT OF
PUBLIC HEALTH & ENVIRONMENT
201 N. 6th Street
Cañon City, CO 81212
P: 719-276-7450 F: 719-276-7451

Immunization Consent Form (Internal)

I have been given a copy and have read the information in the Vaccine Information Sheet for each vaccine checked below. I have had a chance to ask questions and they were answered to my satisfaction. I understand the benefits and risks of each vaccine requested and ask that the vaccine(s) checked below be given to me or to _____Name of Minor Child_____, for whom I am authorized to make this request.

- ☐ Hepatitis B (HBV, HEP B)
- ☐ Hepatitis A (Hep A)
- ☐ Haemophilus Influenzae b (Hib)
- ☐ Inactivated Polio Virus (IPV)
- ☐ Pneumoncoccal Conjugate (PCV)
- ☐ Measels/Mumps/Rubella (MMR)
- ☐ Meningococcal Conjugate (MCV)
- ☐ Rotovirus
- ☐ Diptheria/Tetanus/Acellular Pertussis (Dtap)
- ☐ Diptheria/Tetanus (DT pediatric)
- ☐ Tetanus/Diptheria/Acellular Pertussis (Tdap)
- ☐ Tetanus/Diptheria (Td adult)
- ☐ Human Papillomavirus (HPV)
- ☐ Varicella (VAR)
- ☐ Inactivated Influenza (Flu)
- ☐ Other _____

_____ _____ _____

Signature of Patient/Parent/Legal Guardian Printed Name/Relationship Date

** A consent must be signed in order for a patient to receive an immunization. For children under 18 the consent will be signed by the parent or legal guardian.*

We recommend that you check with your health plan prior to receiving any medical services to assess your benefits and eligibility for coverage.

INSURANCE/PAYMENT INFORMATION -

No Insurance (NI) [ ] Alaska Native (AN) [ ] American Indian (AI) [ ]

Medicare # _____ Medicaid # _____
Private Insurance Name _____ Policy # _____
Group/Plan # _____ Subscriber's Name & DOB _____

By signing, I hereby authorize Fremont County Department of Public Health & Environment to disclose of any portion of the patient's medical record necessary to my insurance for reimbursement of services and request that payment of authorized benefits be made to Fremont County Department of Public Health & Environment.

FCDPHE Office Use Only

Vaccine/Manufacturer_____/_____ Lot Number_____
VIS Date_____ Administration Route/Site_____

Vaccine/Manufacturer_____/_____ Lot Number_____
VIS Date_____ Administration Route/Site_____

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Vaccine/Manufacturer_____/_____ Lot Number_____
VIS Date_____ Administration Route/Site_____

Nurse Administering Signature _____ Date _____

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Immunization Screening Questionnaire

Patient Name: _____ Date of Birth: _____/_____/_____

The following questions are required and are used to help us determine which vaccines your child may be given today. Please circle your response to each question asked. 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.

1.	Is the patient ill today or have a fever?	Yes / No
2.	Has the patient ever had a serious reaction after receiving a vaccine?	Yes / No
3.	If the patient is a child 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	Yes / No / NA
4.	If the patient is a baby, have you ever been told he or she has had intussusception?	Yes / No / NA
5.	Does the patient have an allergy to any medication, latex or a vaccine component?	Yes / No If yes: _____
6.	Does the patient have an allergy to food, egg or egg product?	Yes / No If yes: _____
7.	Does the patient have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	Yes / No If yes: _____
8.	Does the patient have cancer, leukemia, HIV/AIDS, or any other immune system problem?	Yes / No If yes: _____
9.	In the past 3 months, have the patient 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, or psoriasis; or have you had radiation treatments?	Yes / No If yes: _____
10.	During the past year, has the patient received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	Yes / No If yes: _____
11.	Has the patient had a seizure or a brain or other nervous system problem?	Yes / No If yes: _____
12.	Has the patient ever had Guillain-Bare Syndrome?	Yes / No
13.	Is the patient pregnant or is there a chance she could become pregnant during the next 4 weeks?	Yes / No / NA
14.	Has the patient received any vaccinations in the past 4 weeks?	Yes / No

The following puts patients at higher risk for contracting Hepatitis A:

- Traveling to countries that have high rates of Hepatitis A
- Men who have sexual contact with other men
- People who live with or have sexual contact with someone who has Hepatitis A
- Users of injection or non-injection illegal drugs
- People who have chronic liver disease
- People who are treated with clotting-factor concentrates
- People who work with Hepatitis A infected animals or in a Hepatitis A research laboratory

By signing below, I attest that the above information is true and complete to the best of my knowledge, and I am aware that deliberate misrepresentation may jeopardize my health.

Patient/Legal Guardian Signature: _____ Date: _____

FCDPHE OFFICE USE ONLY

Form Reviewed by: _____ Date: _____