Warren County Combined Health District
416 S. East Street Lebanon, Ohio 45036
Child Immunization To Be Given

***Child's Name_____D.O.B.____/____/_____Age____Sex M F**
Last First M.
***Parent or Guardian (print)_____Date_____**

***Address_____City_____Township_____**

Parent/Guardian complete 1st three lines, answer questions, and sign and date bottom

By signing this form you are giving Warren County Health Dept. permission to administer any of the vaccines listed below. When you sign the release for treatment you also acknowledge that you have been notified of Notice of Privacy Practice.

DTAP,DT	**HEPATITIS B**	**Combination Vaccines**
IPV	**HIB**	**PENTACEL** (Dtap-Hib-IPV)
PNEUMOCOCCAL 13	**ROTA VIRUS**	**PEDIARIX** (Dtap-HepB-IPV)
MMR	**VARICELLA**	**KINRIX** (Dtap-IPV)
HEPATITIS A	**MENINGOCOCCAL**	**PROQUAD** (MMR/VARICELLA COMBO)
TD, TDAP	**HPV 9**	**Travel Vaccines:**
		Typhoid
		Yellow Fever

IS THE INDIVIDUAL THAT IS GOING TO RECEIVE VACCINE:

Ill with anything more serious than a cold?.....No__Yes__
Have any allergies? (i.e. eggs, medications, thimerosal, neomycin, baker's yeast, gelatin, polymycin, streptomycin, aluminum, phenoxethanzl, latex).....No__Yes__
Had a serious reaction to a vaccine in the past?.....No__Yes__
Has the child had a health problem with lung,heart,kidney or metabolic disease, asthma, or blood disorder? Is he/she on long-term aspirin therapy?.....No__Yes__
Received a transfusion of blood, plasma, or a medicine called immune globulin in the past year?.....No__Yes__
Had a seizure or neurological problem?.....No__Yes__
Currently nursing a baby?.....No__Yes__
Resides in a home with a newborn infant?.....No__Yes__
If your child is a baby, have you ever been told he/she has had intussesception?.....No__Yes__

DOES THE INDIVIDUAL AND/OR ANYONE LIVING WITH OR TAKING CARE OF THE INDIVIDUAL:

Have cancer, leukemia, AIDS, or any other immune system problem?.....No__Yes__
Has the child taken medications that weaken their immune system, such as cortisone, prednisone, steroids, anticancer drugs, or x-ray treatment in the past 3 months?.....No__Yes__
Pregnant or at risk of becoming pregnant within the next three (3) months?.....No__Yes__
Received any vaccinations in the past four (4) weeks?.....No__Yes__
I HAVE received information concerning "Notice of Privacy Practices".....No__Yes__

I HAVE answered the above questions to the best of my knowledge.
I UNDERSTAND THE BENEFITS AND RISKS OF THE Vaccine(s) and give my consent that the vaccine(s) indicated on this form be given to me or the person named for whom I am authorized to make this request.
I GRANT permission for this record to be released to the following: (Draw a line through and initial beside any you do not authorize release to:

WIC Physician(s) Third Party Payer(s) State Immunization Registry Database

_____DATE_____

SIGNATURE OF PARENT/LEGAL GUARDIAN/CLIENT

Rev 6/21/2016