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**	**QUADRACEL** (Dtap-IPV)
HEPATITIS A	**MENINGOCOCCAL**	**PROQUAD** (MMR/VARICELLA COMBO)
TD, TDAP	**MENINGOCOCCAL B**	**Travel Vaccines:**
	HPV 9	**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 GRANT permission for this record to be released to State Imm. Registry Database?.....No☐Yes☐
I GRANT permission for this record to be released to Third Party Payor(s)?.....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:

_____DATE_____

SIGNATURE OF PARENT/LEGAL GUARDIAN/CLIENT