FCCHD CONSENT Ages Birth thru 18 years

Patient Name: _____ **Date of Birth:** _____/_____/_____ **Male / Female**

Address: _____ **City:**_____ **State:**_____ **ZIP:**_____

S.S.#_____ **Home Phone:** _____ **Cell Phone:** _____

Circle all that apply:	Race:	Hispanic:	Marital Status:	Student:	Employed:
	White Black/Afr Amer Asian Native HI/Other PI Amer Ind/AK Native Other	Yes No	Single Married Divorced Widowed Separated	Full-Time Part-Time No	Full-Time Part-Time Self-Employed Unemployed

PLEASE ANSWER THE FOLLOWING QUESTIONS FOR THE PERSON RECEIVING VACCINE:

1	Is the person sick today?	Yes	No	Not sure
	If yes, what symptoms do they have?			
2	Is the person allergic to any food, medicine, preservative or latex?	Yes	No	Not sure
	If yes, list allergies:			
3	Has the person had any adverse reactions to previous vaccines?	Yes	No	Not sure
	If yes, list vaccines:			
4	Does the person have a medical condition such as HIV/AIDS or cancer that affects their immune system, or are they taking medications or treatments such as cortisone or steroid type drugs, chemotherapy or radiation therapy, or organ anti rejection drugs that affect their immune system?	Yes	No	Not sure
	Does anyone else in the household?	Yes	No	Not sure
5	Has the person received any blood products in the past year, including immune globulin?	Yes	No	Not sure
6	Is the person pregnant?	Yes	No	Not sure
7	Has the person received any vaccinations in the past 30 days?	Yes	No	Not sure
8	Is this person enrolled in WIC?	Yes	No	Not sure

TB TEST ONLY: Have you been tested previously for TB? ___No ___Yes Result: _____ Unknown: _____

Reason for TB skin testing today:	Have you experienced any of the following: Please check any that apply:
_____Required by Employer	_____ Coughing up sputum or blood _____Fatigue/Tiredness
_____ School Entry Requirement	_____ Loss of appetite _____Fever or chills
_____ Possible exposure to TB	_____ Unexplained Weight Loss _____ Night sweats
_____Experiencing Symptoms	_____ Prolonged coughing (longer than 3 weeks)
_____Other:	

I have read or have had explained to me the information about the vaccine(s) being administered. I have received the Vaccine Information Statement (VIS) for each of the vaccines indicated. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) be given to me or to the person named for whom I am authorized to make this request. I have had an opportunity to review the Flathead City-County Health Department Notice of Privacy Practices and receive an individual copy upon request. I have also been informed and understand that confidential health care information concerning me or the person for whom I am legally responsible, which may be provided to the Health Department or recorded in the course of receiving immunization services, is electronically recorded and retained in the Montana Public Health Data System. You are expected to pay the co-payment and deductible payments required by your insurance coverage and all charges for services not covered by your insurance plan.

X			
Signature of person to receive vaccine(s) or person authorized to make the request if recipient is less than 18.	Initials	Relationship to person receiving vaccine	DATE

Complete this section if you wish to authorize another adult to consent for immunizations for your child at this visit.
You **MUST** provide a phone number. You will be called during the immunization appointment.

I authorize (*print adult's name*)	to initial for consent for this child	Parent Phone:	
X	X		
Signature of parent or legal guardian	Signature of authorized adult	Initials	Date