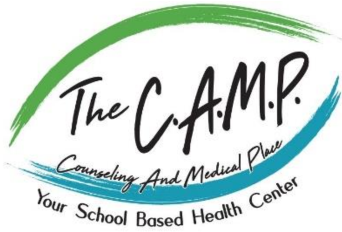

700 Newberry Avenue, Room 170
Newberry, MI 49868
Office Hours: 7:30am – 3:30pm, Monday - Friday
906-293-3226 ext 1427
Fax: 906-293-1547

IMMUNIZATION QUESTIONNAIRE AND CONSENT FORM

Enclosed is a copy of your child's Michigan Care Improvement Registry (MCIR) immunization record & information sheets for each eligible vaccine. Please mark consent or decline on the front of the form. If you would like your child to receive the recommended vaccines, please fill out the parent consent/immunization questionnaire **on the back of this form** as well – it must be completed prior to your child receiving services. Once we have received the completed form we will then schedule an appointment. Please know that declining certain immunizations may require an additional appointment with LMAS District Health Department to obtain a signed immunization waiver.

According to the Michigan Care Improvement Registry (MCIR) records, ___________________________ needs the immunizations highlighted below.

<u>Please check the boxes below indicating the vaccine(s) you wish to consent or decline for your child.</u>

Vaccine due date:	Vaccine:	*Consent*	*Decline*	Reason for refusal:
	Tetanus Diphtheria Pertussis (Tdap)			
	Varicella (chicken pox) series*			
	Seasonal Influenza			
	Hepatitis A series *			
	Meningococcal series *			
	Human Papilloma Virus (HPV) series *			
	Meningococcal B series *			

**** Please note: By giving consent to a vaccine that is part of a series, I am giving my consent for the administration of all vaccines needed as a part of the series.***

I have been given a copy and have read, or have had explained to me, the information contained on the appropriate Vaccine Information Statement (VIS) about the disease(s) and the vaccine(s) which are due. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the specific vaccine(s) and I ask that the vaccine(s) series indicated about be given to the person named above, for whom I am authorized to make this request. I ask that the administration of the vaccine(s) be recorded in MCIR. I understand the possible consequences 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.

Printed Name of Parent/Guardian:_______________________ **Signature:**__________________________ **Date:**________

Mailing Address:____ **Phone Number:**_______________________

Over -

Age-appropriate immunizations are provided to children and adults subject to availability of vaccines, and in accordance with policies of the Michigan Department of Health and Human Services and this clinic.

Information on person to be immunized:

Patient's Name: Date of Birth: Gender:

Do you have health insurance? Yes No If yes, does it cover immunizations? Yes No

________________________ Policy #______________________________ Group #__________________

Are you currently on Medicaid? Yes No Policy #____________________________________

Are you currently on Medicare? Yes No Policy #_____________________________________

Are you a Native American or Alaska Native? Yes No

Screening Questionnaire for Child and Teen Immunization

The following questions will help us determine which vaccine(s) your child may be given today. If you answer yes to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.
Please circle Yes, No or Unknown for each question.

1. Is the child sick today? Yes No Unknown
2. Does the child have allergies to medications, food, a vaccine component or latex? Yes No Unknown
   If yes, please list allergies:
3. Has the child had a serious reaction to a vaccine in the past? Yes No Unknown
4. Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g. diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy? Yes No Unknown
5. Has the child, a sibling, or a parent had a seizure? Yes No Unknown
6. As the child had brain or other nervous system problems? Yes No Unknown
7. Does the child have cancer, leukemia, AIDS or any other immune system problem? Yes No Unknown
8. In the past 3 months, has the child taken cortisone, prednisone, other steroids, anticancer drugs, or had radiation treatments? Yes No Unknown
9. In the past year, has the child received a transfusion of blood or blood products, or been given immunoglobulin or an antiviral drug? Yes No Unknown
10. Is the child pregnant or is there a chance she could become pregnant during the month? Yes No Unknown
11. Has the child received vaccinations in the last 4 weeks? Yes No Unknown

Your health insurance will be billed for the cost of the vaccine(s) and administration. Payment received will be considered payment in full, no bill will be sent to you for immunizations administered at The CAMP.

If you have questions or concerns please call The CAMP at 906-293-3226 ext 1427.