Benzie-Leelanau District Health Department
School Based Immunization Clinic

Immunization Consent Form

Student Name: _____ Date of Birth: _____
Last First Middle

Address: _____
Street/PO Box City Zip

Parent/Guardian Name: _____ Phone Number: _____

Insurance Information: ____My child does not have insurance (or doesn't have insurance that covers immunizations)

Insurance Company:_____

Insured Name:_____ Date of Birth:_____

Policy ID#_____ Group #_____

Employer Name:_____

Please answer the following questions:

	YES	NO	DON'T KNOW
Does this person have allergies to medications, food, latex or a vaccine component?			
Has this person had a serious reaction to a vaccine in the past?			
Has this person, a sibling, or a parent had a seizure; or does this person have brain or other nervous system problems?			
Does this person have cancer, leukemia, HIV/AIDS, or any other immune system problem?			
In the past 1-3 months, has this person 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 had radiation treatment?			
In the past year, has this person received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?			
Is this person pregnant or is there a chance she could become pregnant in the next month?			
Has this person received vaccinations in the past 4 weeks?			

I request immunizations be given to the student named above, for whom I am authorized to make this request, by Benzie-Leelanau District Health Department staff, at the School Based Immunization Clinic. I have had a chance to review Vaccine Information Sheets and have had my questions answered to my satisfaction. I am aware that this information may be shared with my physician and with local and state immunization registries, and for payment purposes, with my insurance carrier.

If I have provided medical insurance information, I give consent to bill my insurance for vaccines administered.

I consent for my child to be immunized for the following:

- ☐ All recommended vaccines
- ☐ All recommended vaccines EXCEPT _____

Parent/Guardian Signature:_____ Date:_____