HENRY COUNTY PUBLIC health

# VACCINE HEALTH QUESTIONNAIRE

## Please list all individuals receiving vaccines today — complete one row per person:

| # | Name (First Last) | Date of Birth | Age | Sex | Weight (children only) | List Any Allergies Are Calming Tools Needed? |
|---|---|---|---|---|---|---|
| 1 | | | | ☐ M ☐ F | | Allergies: _____ Optional calming tools? ☐ Yes *Available tools include weighted lap blankets, cold spray, dimmed lights, Buzzy, shot blocker, and more.* |
| 2 | | | | ☐ M ☐ F | | Allergies: _____ Optional calming tools? ☐ Yes |
| 3 | | | | ☐ M ☐ F | | Allergies: _____ Optional calming tools? ☐ Yes |
| 4 | | | | ☐ M ☐ F | | Allergies: _____ Optional calming tools? ☐ Yes |

**Address:** _____

Street City State Zip Code

| Vaccine Screening Questions | Vaccine Recipient #1 | | Vaccine Recipient #2 | | Vaccine Recipient #3 | | Vaccine Recipient #4 | |
|---|---|---|---|---|---|---|---|---|
| | Yes | No | Yes | No | Yes | No | Yes | No |
| 1. Has the person been very sick in the last 24 hours? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Is the person currently taking medication? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Has the person ever had a serious reaction to a vaccine? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Does the person have cancer, leukemia, lymphoma, or receiving drugs that lower the body's resistance to infection? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. Does the person have a parent or sibling with an immune system problem? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6. Has the person had a seizure or brain problem? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 7. Has the person ever had Guillain-Barre Syndrome? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 8. Is the person American Indian/Alaska Native? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 9. Has the person received vaccinations in the last 4 weeks? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 10. Has the person received a blood transfusion or immune globulin in the past year? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 11. ***For babies***: Have you been told the child had intussusception? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 12. Does the person have a history of myocarditis or pericarditis? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 13. Does the person have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**Explain any "Yes" answers to the Vaccine Screening Questions:**

| Recipient # | Question # | Medication, reaction, or other details |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

| **Minor Vaccination Consent** *(Complete if with a child under age 18)* | Parent/Guardian Name: _____ |
|---|---|
| Relationship to Minor: _____ | Parent/Guardian Phone Number: _____ |

**Consent for Vaccination**

I, the undersigned parent or legal guardian of the above-named minor, authorize and consent to the administration of recommended immunizations/vaccinations to this minor by authorized healthcare personnel.

- I have received or been offered the applicable Vaccine Information Statement(s) (VIS).
- I have had the opportunity to ask questions regarding the vaccine(s).
- I understand the benefits and potential risks associated with vaccination.
- I authorize medical personnel to administer the vaccine(s) deemed appropriate.

**Vaccines Authorized**

☐ All age-appropriate vaccines

(this **may** include: tetanus, diphtheria, pertussis, polio, pneumococcal, haemophilus influenzae type b, rotavirus, respiratory syncytial virus, Hepatitis A, Hepatitis B, human papillomavirus, measles, mumps, rubella, varicella, meningococcal ACWY and B.)

OR

☐ Specific vaccines only:_____

**Parent/Guardian Signature:** _____ **Date:** _____

***OFFICE USE ONLY:***

Telephone consent for vaccination was obtained from the parent/legal guardian and verified by the following staff members:

Signature: _____ Date: _____

Signature: _____ Date: _____

## Insurance Authorization and Financial Responsibility

☐ I do not have insurance ☐ My insurance does not cover vaccines

Insurance Company Name: _____ Policy Holder Date of Birth: _____

Policy Holder Name: _____ Policy Holder Sex: ☐ M ☐ F

I certify that the insurance information provided is correct. I authorize release of records required to process claims and request that authorized benefits be paid directly to Henry County Public Health for all who may be covered by this insurance. I understand that if insurance does not pay, I may be billed for today's services.

**Signature:** _____ **Date:** _____