Delaware General Health District
Dedicated to Your Health

Child Consent Form

Please Print Clearly

First Name _____ MI _____ Last Name _____ Gender _____ Age _____

Address _____ City _____ State _____ Zip code _____

Phone: _____ Email: _____ Birthdate: ____ (Month) ____ (Day) ____ (Year)

Race : _____ Ethnicity (Please circle one) : Hispanic/ Latino Not Hispanic/Latino Preferred Language : _____

Insurance Company _____ Member ID _____ Group # _____

Claim Submission Address _____ Social Security # _____

Primary Insured Name _____ Birthdate _____ Relationship to Patient _____

Address (If different from patient _____

Secondary Insurance Company _____ Member ID _____ Group # _____

Claim Submission Address _____ Social Security # _____

Primary Insured Name _____ Birthdate _____ Relationship to Patient _____

Address (If different from patient _____

NO INSURANCE	Household Size:		Household Income:		Per Week/Month/Year

Please Answer the following Questions	Yes	No
Is your child sick today?		
Does the child have allergies to medications, food, a vaccine component, or latex?		
Has the child had a serious reaction to a vaccine in the past?		
Does the child have a long-term health problem with heart, lung, kidney, neurologic, liver, or metabolic disease (e.g., diabetes), asthma, or a blood disorder?		
If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?		
Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problems; or in the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, long-term aspirin therapy, anti-viral drugs, or anticancer drugs; drugs for the treatment		
Has the child, a sibling, or a parent had a seizure or other nervous system problem (e.g. Guillain Barre Syndrome) ?		
Does the child live with or have close contact with someone who is in protective isolation (e.g. bone marrow transplant unit) ?		
Has the child received vaccinations in the past 4 weeks?		
For Teen Females: Is your teen pregnant?		
For Infants: have you ever been told your child has had intussusception?		

The Delaware General Health District may keep this record in my child's medical file. DGHD will record what vaccine was given, the date the vaccine was given, the name of the company that made the vaccine, the vaccine lot number, the signature and title of the person who gave the vaccine, and the address where the vaccine was given. I understand that this information will be released to a state-wide Immunization Registry for the purpose of immunization tracking recall and recording, unless I request otherwise. I have read or have had explained to me the information sheet about the vaccine. I have had a chance to ask questions, and they were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the vaccine be given to the person named above for whom I am authorized to make this request. My medical information will not be shared without an authorization to release information. A copy of the Health Districts Notice of Privacy Practices (HIPAA) will be provided and is also located on our website at delawarehealth.org. I authorize my insurance company to assign the amount payable directly to DGHD.

I understand that I am financially responsible for all the charges that are not covered under my insurance plan. I acknowledge that any co-payment is due and payable on the date services are received.

Parent/Guardian Name (please print clearly): _____ Parent/Guardian DOB: _____

Relationship to Patient: _____

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

OFFICE USE ONLY

☐ Dtap	☐ Hib	☐ Polio	☐ Hep B	☐ Prevnar-13	☐ Rotarix	☐ Dtap-Hib-Polio	☐ MMR	☐ Varicella	☐ Flu Shot
☐ MMR - V	☐ Dtap-Polio	☐ Tdap	☐ TD	☐ Meningococcal ACWY	☐ HPV	☐ Meningococcal B	☐ Hep A	☐ Rabies	☐ Flu Mist

STOP — For Office Use Only

Vaccine Administration Record

VACCINE	DOSE #	LOT #	SITE	RN SIGNATURE	DATE
DTAP 90700 under 7 years			LVL RVL LD RD IM		
HPV GARDASIL 9 90651			LD RD IM		
HEP A 90633			LVL RVL LD RD IM		
HEP B 90744			LVL RVL LD RD IM		
HIB 90648			LVL RVL LD RD IM		
IPV (Polio) 90713			LVL RVL LA RA SQ IM		
(Dtap, Polio) 90696			LD RD IM		
MENINGOCOCCAL 90734			LD RD IM		
MENINGOCOCCAL B 90620			LD RD IM		
MMR 90707			LVL RVL LA RA SQ		
MMRV 90710			LVL RVL LA RA SQ		
PENTACEL (DTAP,IPV,HIB) 90698			LVL RVL LD RD IM		
PREVNAR-13 90670			LVL RVL LD RD IM		
RABIES 90675			LD RD IM		
ROTA-X 90681			PO		
TDAP 90715 7 years & older			LD RD IM		
TD 90714			LD RD IM		
VARICELLA 90716			LVL RVL LA RA SQ		
6-35 mth Flu 90685			LVL RVL LD RD IM		
Flu Pres. free 90686			LVL RVL LD RD IM		
Flu Mist 90672			Nasal		
FluBlok 90673			LVL RVL LD RD IM		
TOOTH VARNISH D1208			EXP. DATE		
Diluent					
Nursing Assessment 99211	Notes:				

Administrative Assistant	
Time IN	
NN Number	
Insurance Verified	
Primary Insurance	
VFC	Private
NN Completed	
Impact Completed	

Medicaid Patients—Under 6	
Tooth Varnish Applied	Y or N

Doctor Information	
☐ Notification of Vaccination Form Filled Out	
Last Well Visit	
Will the child be returning to DGHD for vaccines?	Y OR N
ACTIVE	INACTIVE

Nurse	
Time Completed	
NN Completed	
Impact Completed	