Delaware Public Health District
Dedicated to your health

Child Consent Form

Child's First Name: _____ MI: ____ Last Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____Email: _____ Birthdate: _____ Age: _____

Race: _____ Preferred Language:_____ **Sex** [ ] Male [ ]Female **Hispanic/Latino?** [ ] Yes [ ]No

Please Answer the Following Questions:	Yes	No	Not Sure
1. Is your child sick today?			
2. Does the child have allergies to medications, food, a vaccine component, or latex?			
3. Has the child had a serious reaction to a vaccine in the past?			
4. Does the child have a long-term health problem with heart, lung (including asthma), kidney, liver, nervous system, or metabolic disease (e.g., diabetes), a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are they taking regular aspirin or salicylate medication?			
5. 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?			
6. For babies: Have you ever been told the child had intussusception?			
7. Has the child, a sibling, or a parent had a seizure; has the child had a brain or other nervous system problem?			
8. Has the child ever been diagnosed with a heart condition (myocarditis or pericarditis) or have they had Multisystem Inflammatory Syndrome (MIS-C) after an infection with the virus that causes COVID-19?			
9. Does the child have an immune-system problem such as cancer, leukemia, HIV/AIDS?			
10. In the past 6 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs to treat rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?			
11. Does the child's parent or sibling have an immune system problem?			
12. In the past year, has the child received immune (gamma) globulin, blood/blood products, or an antiviral drug?			
13. Is the child/teen pregnant?			
14. Has the child received vaccinations in the past 4 weeks?			
15. Has the child ever felt dizzy or faint before, during, or after a shot?			
16. Is the child anxious about getting a shot today?			
Questions 17-23 for TB Testing ONLY:	**Yes**	**No**	**Not Sure**
17. Has the child ever had a TB skin test before?			
18. Has the child ever had a positive TB skin test?			
19. Has the child ever been diagnosed with TB?			
20. Has the child ever been told not to have a TB skin test?			
21. Has the child been asked to come in for a test because someone you know has been diagnosed with TB?			
22. Has the child had BCG vaccination before?			
23. Does the child need a 2-step TB skin test? (2 tests performed within 1-3 weeks; Some health care workers need this)			

Insurance Subscriber's First and Last Name: _____ Sex [ ] Male [ ] Female

Insurance Subscriber's Date of Birth: _____ Relationship to Patient: _____

Address (if different than patient): _____

If you do not have insurance, please answer the following information:

Household Size:_____Household income:_____Frequency of income: [ ] per week [ ] per month [ ] per year

The Delaware Public Health District may keep this record in the patient's medical file. DPHD will record what vaccine or service was given, the date the vaccine or service 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 and any screening or service provided with date and person providing the service. 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 understand that this information will be released and received from a healthcare provider interoperability Hub (e.g. carequality/ commonwell) for the purpose of sharing and providing patient care, unless I request otherwise. I understand that appointment, cancellation, and reminder information will come to me through email, phone call, and/or text, unless I request otherwise. I understand these permissions will be valid until revoked. For TB: The clinic will keep this form for seven years if result is negative and permanently if the result is positive. It will include information when TB test was given, PPD lot #, result and name and address of where the test was given.

I have read or have had explained to me the information sheet about the vaccine, TB test, or service to be received today. 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 or service and ask that the vaccine or service be given to the person named above for whom I am authorized to make this request. Except as outlined above and in the notice of privacy practices, my medical information will not be shared without an authorization to release information. I have received the Health District's Notice of Privacy Practices (HIPAA) and it is also located on our website at delawarehealth.org. I authorize my insurance company to assign the amount payable directly to DPHD. I understand that I am financially responsible for all the charges that are not covered under my insurance plan or elective service. I acknowledge that any co-payment is due and payable on the date services are received.

Parent/Guardian Name (Print)_____Relationship to Patient_____

Parent/Guardian Signature: _____Date:_____

VACCINE	CPT	Route	Dose #	Lot #	SITE	
Chikungunya-IXCHIQ	90589	IM			LD RD	LVL RVL
Cholera- Vaxchora	90625	PO			Mouth	
COVID-19 – Moderna Monov 6mo-11yr Moderna Monov 12+	91321 91322	IM			LD RD	LVL RVL
DTaP – Daptacel	90700	IM			LD RD	LVL RVL
DTaP-IPV - Quadracel	90696	IM			LD RD	LVL RVL
DTaP–IPV-HIB - Pentacel	90698	IM			LD RD	LVL RVL
DTaP -IPV- HBV- HIB - Vaxelis	90697	IM			LD RD	LVL RVL
Flu Pres. Free – Fluzone 6m+ PFS Fluarix	90686	IM			LD RD	LVL RVL
Flu (ccIIV$)- Flucelvax 6mo PFS	90674	IM			LD RD	LVL RVL
FluMist	90672	nasal			Nasal	
HepA-Ped 0.5ml – Vaqta Ped/Adol	90633	IM			LD RD	LVL RVL
HepB Ped 0.5ml - Recombivax HB Ped/Adol	90744	IM			LD RD	LVL RVL
HIB - ActHIB	90648	IM			LD RD	LVL RVL
HPV - GARDASIL 9	90651	IM			LD RD	LVL RVL
IPV - IPOL	90713	SQ / IM			LD RD LA RA	LVL RVL
J.E. (Ixiaro) - Japanese Enceph	90738	IM			LD RD	LVL RVL
MENINGOCOCCAL ACWY - MenQuadfi	90619	IM			LD RD	LVL RVL
MENINGOCOCCAL B - Bexsero	90620	IM			LD RD	LVL RVL
MMR - MMRII	90707	SQ			LA RA	LT RT
MMRV - Proquad	90710	SQ			LA RA	LT RT
PREVNAR 20	90677	IM			LD RD	LVL RVL
PNEUMO CONJ 15- Vaxneuvance	90671	IM			LD RD	LVL RVL
PNEUMO 23 – Pneumovax23	90732	SQ / IM			LD RD LA RA	
RABIES - Imovax	90675	IM			LD RD	LVL RVL
Rotavirus - Rotarix	90681	PO			Mouth	
RSV- infant Beyfortus 50mg Beyfortus 100 mg	90380 90381				LD RD	LVL RVL
TDAP- Adacel	90715	IM			LD RD	
Typhoid – Typhim Vi	90691	IM			LD RD	LVL RVL
VARICELLA - Varivax	90716	SQ			LA RA	
Yellow Fever	90717	SQ			LA RA	LT RT

TB Step 1	Placed:	RN:	Read:	RN:	Assess: mm	Result: + / -	Lot #:	LFA RFA
TB Step 2	Placed:	RN:	Read:	RN:	Assess: mm	Result: + / -	Lot #:	LFA RFA

Vaccine Administrator Signature: _____ Date: _____

Admin

Delaware [ ] Other location:_____ VFC [ ] State [ ] Private [ ] Insurance Verified or % on Sliding Fee: _____

Primary Pay Source:_____Member ID: _____

Secondary Pay Source: _____ Member ID: _____

eCW Chart created: _____ Scanned into eCW:_____

For TB-

Paid for Step 1 (initial) _____

Paid for Step 2 (initial) _____

For TB-

Bill to employer: LF invoice made: _____ Date: _____ LF invoice paid:____ Date: _____

Nurse

ImpactSIIS Status: ACTIVE / INACTIVE

eCW charting completed: _____

Notes:

Sign In:_____ Admin completed:_____ RN received:_____ RN completed:_____