Roundup Memorial
Healthcare

CHILD IMMUNIZATION CONSENT FORM

All information collected on this form is strictly confidential and will become part of your medical record.

Child Name: *(Last, First, M.I)*	**Birth Date:** / /	**Age:**
Parent/Guardian Name: *(Last, First, M.I)*		**Sex:** M ☐ F ☐
Address:		**Phone No.:** ( )
City/State:	**Zip Code:**	**Alternate Phone No.:** ( )

Insurance Information

Please check which pertains to your child: ☐ Does not have health insurance ☐ My child's health insurance does **not** include vaccines ☐ My child's insurance only covers select vaccines List vaccines covered: _____
☐ My child's vaccine coverage is capped at a certain amount Amount of cap: $_____

Name of Insurance: **MUST**☐ **MACo**☐ **Healthy MT Kids Plus** ☐ **Healthy MT Kids** ☐ **Other** ☐_____

Subscriber's name: _____	**Group number:**	**Cash:** ☐ **Check:** ☐ **Check Number:** _____
Relationship to Subscriber Child ❑ Other ❑ _____	**Subscriber's Birth Date:** / /	**Health ID Number:**

It is the policy of Central Montana Health District that no child will be refused immunizations due to inability to pay. Please mark the following box if you are unable to pay for immunizations. **Unable to Pay** ☐

The following information will be used for statistical reports only.

1. **What is child's race?** (please check all that apply)

White ☐ Native American/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Other ☐

2. **Is the child of Hispanic or Latino origin?** Yes ☐ No ☐

3. **Does the child have any special health care needs (congenital/chronic medical conditions)?** Yes ☐ No ☐

Screening:

Parents/Guardians: The following questions will help us determine which vaccines your child may be given. 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.

Is your child sick today? Yes ☐ No ☐

Does your child have any of the following? Yes ☐ No ☐

If yes, please circle: Asthma Leukemia Lung, heart or kidney disease
Diabetes or other metabolic disease HIV/AIDS
Cancer Blood Disorder Liver disease Any other immune system disorder

Does your child have allergies to foods, medications, latex or had a serious reaction to past vaccines? Yes ☐ No ☐

Please describe:_____

Has the child, a sibling or a parent ever had a seizure or other nervous system problems? Yes ☐ No ☐

In the past three months, has your child taken prednisone or other steroids or anticancer drugs, or had radiation treatments? Yes ☐ No ☐

In the past year, has your child received a blood tranfusion or been given immune (gamma) globulin or an antiviral drug? Yes ☐ No ☐

If your child is between ages 2 to 4 years, has a Health Care Provider told you the child had wheezing or asthma in the past 12 months? Yes ☐ No ☐

If your child is a baby, have you ever been told he or she has had intusseption? Yes ☐ No ☐

Has your child received any immunizations in the past 4 weeks? Yes ☐ No ☐

Is your child/teen pregnant or is there a chance she could become pregnant during the next month? Yes ☐ No ☐

****FORM CONTINUED ON BACK****
Please complete both sides of Form

CHILD IMMUNIZATION CONSENT FORM - Continued

Marked are the vaccine(s) your child is due for*:

- ☐ **DTaP**; Tdap****
- ☐ **IPV (Polio)****
- ☐ **MMR****
- ☐ **Varicella (Chickenpox)****
- ☐ **Gardasil (HPV Vaccine)****
- ☐ **Meningococcal (Meningitis Vaccine)****
- ☐ **Hepatitis A****
- ☐ **Hepatitis B****

*If you would like differing vaccinations please indicate which vaccines or contact CMHD with questions, please call Michelle Martin, LPN at **(406) 323-3337 ext. 4906** and she will be happy to assist you.
Links to **Vaccine Information Sheets (VIS) are available on the Central Montana Health District website: www.cmhd-fcno.org under the **Daycare Requirements Tab** or you may also find the VIS's on the Centers for Disease Control Immunization website: www.cdc.gov/vaccines. Vaccine Information Sheets will also be sent home with your child or you may call Michelle Martin, LPN at **(406) 323-3338 ext. 4906** prior to the clinic day and she will assist you.

I have had the opportunity to read the Vaccine Information Sheet(s) and have had a chance to ask questions. The risks and benefits have been explained to me and questions have been answered to my satisfaction. My signature below indicates that I consent to the vaccine(s) to be given to me or the person named above for whom I am authorized to make this request. I give this consent without coercion or reservation. I also give permission to the Roundup Memorial Healthcare (RMH) to release health care information regarding any vaccinations or reactions to the Health Care Provider I have specified and give RMH consent to bill the insurance as named for services rendered. I authorize my insurance benefits be paid directly to Roundup Memorial Healthcare. I understand that I am financially responsible for any balance. I also authorize Roundup Memorial Healthcare and/or my insurance company to release any information required to process my claims.

I authorize my health care provider and/or Roundup Memorial Healthcare to collect and enter my child's immunization records into the Department of Public Health and Human Services' Immunization Information System (IIS). The IIS is a confidential, computer system that contains immunization records. I understand that information in the registry may be released to Roundup Memorial Healthcare as well as my health care providers to assist in my child's medical care and treatment. In addition, information may be released to child care facilities and schools in which my child is enrolled to comply with state immunization requirements. I understand that I can revoke this authorization and have my record removed at any time by contacting Roundup Memorial Healthcare.

By signing this form, I confirm that I have been given/offered a copy of the RMH Notice of Privacy Practices* and have had my questions answered to my satisfaction. The above information is true to the best of my knowledge.

X _____ _____

Signature of Parent or legally responsible person — Date

*A copy of the RMH Notice of Privacy Practices will be available at the clinic site. You may also call the RMH at **(406) 323-3337** prior to the clinic day and request a copy to be mailed to you.