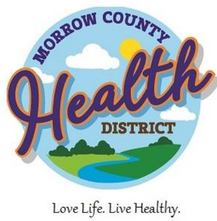

Immunization Clinic

Prior Authorization

Child's Full Name:____ Date of Birth: __________________

I ____ the undersigned parent, legal guardian, or
(Parent/Guardian's Full Name)

person having legal custody of do hereby authorize ______________________________________ to
(Name of Adult Bringing Child)

represent me as Guardian. The listed representative may provide consent to the appropriate licensed health care provider at Morrow County Health District to proceed with the administration of the age-appropriate vaccine(s) for my child, a minor, noted above. Please send the child's shot record and insurance card (as applicable) to the appointment.

YOU MUST INITIAL NEXT TO EACH IMMUNIZATION THAT YOU WISH FOR YOUR CHILD TO RECEIVE (SEE BACK).

Please complete the following questions about the person receiving immunizations:

YES	NO	HAS THE CHILD EVER HAD:
		Convulsions or seizures?
		A severe reaction to any vaccine, eggs, medication, or gelatin?
		Does the patient have cancer, leukemia, AIDS, or any other immune system problem, or have they taken cortisone, prednisone, or other steroids, or anticancer drugs in the last 3 months?
		Is the patient sick today?
		Is this person pregnant or might they become pregnant in the next month?
		Has the patient had any blood, plasma, or immune globulin transfusion in the last 6 months?

If you answered yes to any of the above questions, please provide additional information on the back of this form.

Please **initial** next to each vaccine that you wish for your minor child to receive at the Morrow County Health District Immunization Clinic.

_______ DTaP

_______ Hib

_______ Polio

_______ Hepatitis B

_______ Pneumococcal

_______ Rotavirus

_______ Flu

_______ MMR (Measles, Mumps, Rubella)

_______ Varicella (Chickenpox)

_______ Hepatitis A

_______ Tdap

_______ Meningococcal

_______ HPV (Human Papillomavirus)

_______ Td

Please use the space below to explain any special considerations:

____
____
____
____
____
____
____

I have been provided a copy of the Vaccine Information Sheet(s) and have had an opportunity to have all of my questions answered to my satisfaction. I believe that I understand the risks and benefits of the vaccine(s) and ask that the vaccine(s) initialed above be given to the person named on this form. I certify that I am a parent or legal guardian and am authorized to consent to these services. I grant permission for record of the vaccine(s) given to be entered into the state immunization registry and for Morrow County Health District to request and receive vaccine records from previous providers as needed.

Parent/Guardian Signature: ______________________________Date: ______________

Parent's Phone Number: ________________________