Delaware Public 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: MM/DD/YYYY

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

NO INSURANCE - PLEASE FILL OUT	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 of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?		
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?		
Has your child been identified as either a probable or confirmed case of COVID-19 in the past three months?		
Are you planning to bring your child back to Delaware Public Health District for future vaccinations?		

Primary Physician: ____ Location: ____

☐ My child does not have a primary care doctor.

The Delaware Public Health District may keep this record in my child's medical file. DPHD 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 DPHD.

Parent/Guardian Name (please print clearly): | Relationship to Patient:

Parent/Guardian Signature: | Date:

☐ Primary Insurance Card Scanned ☐ Secondary Insurance Card Scanned (If Applicable) SKIP Below if insurance cards have been scanned

Insurance Company | Member ID | Group #

Claim Submission Address | Social Security #

Primary Insured Name | Birthdate | Relationship to Patient:

Address (If different from patient)

VACCINE	DOSE #	LOT #	SITE	RN SIGNATURE	DATE
DTAP - IM Daptacel 90700			LVL RVL LD RD		
HPV - IM GARDASIL 9 90651			LD RD		
HAV - IM Vaqta 90633			LVL RVL LD RD		
HBV - IM Engerix - B / Recombivax HB 90744			LVL RVL LD RD		
HIB - IM ActHIB / Hiberix 90648			LVL RVL LD RD		
IPV - SQ / IM IPOL 90713			LVL RVL LA RA LD RD		
DTAP-IPV - IM Kinrix / Quadracel 90696			LD RD		
MENINGOCOCCALACWY - IM Menquadfi 90619			LD RD		
MENINGOCOCCAL B - IM Trumemba 90621 Bexsero 90620			LD RD		
MMR - SQ MMR-II 90707			LVL RVL LA RA		
MMRV - SQ 90710			LVL RVL LA RA		
DTAP–IPV-HIB - IM PENTACEL 90698			LVL RVL LD RD		
DTAP– HBV—IPV - IM PEDIARIX 90723			LVL RVL LD RD		
PREVNAR-13 - IM 90670			LVL RVL LD RD		
RABIES - IM Rabavert / Imovax 90675			LD RD		
Rotavirus - PO Rotarix / Rotateq 90681			PO		
TDAP- IM Adacel / Boostrix 90715			LD RD		
TD - IM 90714			LD RD		
VARICELLA - SQ Varivax 90716			LVL RVL LA RA		
Dtap-IPV- HBV- HIB Vaxelis - IM 90697			LVL RV LD RD		
Flu Pres. Free - IM 90686			LVL RVL LD RD		
Flu Mist 90672			Nasal		
FluBlok - IM 90682			LVL RVL LD RD		
JE –VC - IM Japanese Encephalitis IXIARO 90738			LD RD		
Typhoid - IM Typhim Vi 90691			LD RD		
COVID-19 - IM Moderna / Pfizer			LVL RVL LD RD		

Administrative Assistant	
DELAWARE	SUNBURY
Time IN	
NN Number	
Insurance Verified or % on Sliding Fee	
Primary Pay Source	
VFC	PRIVATE
NN Completed	
Impact Completed	

NURSE - Initials	
Time completed	
NN Completed	
Impact Completed	

ACTIVE	INACTIVE

Diluent

Notes