Total Health Care

Last Name:_____
Date:_____

CHILD IMMUNIZATION CONSENT FORM

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

Child Name:	**Birth Date:**	**Age:**
Birth Sex: ☐ M ☐ F	**Gender Identity:** ☐ M ☐ F ☐ Transgender ☐ Non-Binary ☐ Decline	
Address:	**City/State:**	**Zip Code:**
Parent/Guardian Name:	**Home #:**	**Cell #:**
School Name:	**Email Address:**	

The following information will be used for statistical reports only.

Child's race (Circle all that apply)

Asian Black/African American Native American/Alaska Native Native Hawaiian/Pacific Isander White Other

Do you identify as Hispanic/Latino? ☐ Y ☐ N

Insurance Information & VFC Eligibility Screening

Please check which statement pertains to your child (If any):

- ☐ Does not have insurance
- ☐ Health insurance does *not* include all/some vaccines – **underinsured**
- ☐ Child's vaccines/medical coverage is capped at a certain amount (amount of cap: $_____) – **underinsured**

Screening

The following questions help us determine which vaccines your child may receive.
If you answer "yes" to any question it does not necessarily mean your child should not receive a vaccine.

Is your child sick today?

Does your child have any of the following? If yes, please circle:

Asthma Leukemia Lung/heart/kidney disease HIV/AIDS Cancer Diabetes or other metabolic disease
Blood disorder Liver disease Any other immune system disorder

Does your child have allergies to foods, medications, latex or had serious reaction to past vaccines? Y N
If yes, please describe:_____

Has the child, a sibling, or a parent ever had a seizure or nervous system problem? Y N

In the past 6 months has your child taken prednisone/other steroids/anticancer drugs or had radiation treatment? Y N

In the past 1 year has your child received a blood transfusion or been given immune (gamma) globulin or an antiviral drug? Y N

Has your child received any immunizations in the past 4 weeks? Y N
If yes, please list:_____

Is your child/teen pregnant or is there a chance they could become pregnant in the next month? Y N

Has your 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? Y N

Does the child's parent or sibling have an immune system problem? Y N

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Your child is due for the following vaccines:

School Required		CDC Recommended	
Parent/Guardian please initial beside each consented vaccine to be given			
☐ **DTaP/Tdap** *(tetanus, diphtheria, pertussis)*		☐ **Hepatitis A**	
☐ **Hemophilus**		☐ **Human papillomavirus** *(HPV)*	
☐ **Hepatitis B**		☐ **COVID-19**	
☐ **IPV** *(polio)*		☐ **Influenza**	
☐ **MMR** *(measles, mumps, rubella)*			
☐ **Meningococcal**			
☐ **Pneumococcal**			
☐ **Varicella**			

HEALTH INSURANCE INFORMATION – PLEASE FILL OUT COMPLETELY AND ACCURATELY

Please copy this information from YOUR INSURANCE CARD. We will bill your insurance. You will NOT be charged a co-pay or a deductible.

Type of Insurance: **Private Insurance or Medical Assistance** **My child does not have health insurance** (Your child will not be turned away because of no insurance)

Insurance Company Name	**Member ID Number** (write in boxes below)
	Group Number (write in boxes below)

FOR PRIVATE INSURANCE ONLY

Policy Holder's/Insured Adult's Name	**Relationship to Student**	**Insured Adult's Birthday**	**Any Other # from Insurance Card**

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PERMISSION TO VACCINATE WITHOUT PARENT PRESENT – YOU MUST SIGN HERE FOR YOU CHILD TO BE VACCINATED

By signing below, I affirm that I am the parent, guardian or legal representative authorized to consent to medical treatment for my child listed and I hereby consent to and give permission for authorized other medical professionals authorized by Baltimore City Public Schools to administer the vaccines listed above and for vaccine(s) entered into ImmuNet, Maryland's immunization registry. Further, I agree that the information above is correct, and:

(1) I expressly consent to the administration of the vaccines listed above, **without my physical presence**.
(2) I understand that if my child exhibits disruptive behavior while staff is trying to administer vaccinations, they will not receive the vaccines at school, and I will have to accompany them to school or their provider for their required vaccines. In the event of an emergency situation, emergency medication (such as Epinephrine/Benadryl) and/or oxygen may be administered to my child. In the event of an emergency situation where I am not present, I authorize the Maryland Partnership for Prevention and/or other medical professionals authorized by Baltimore City Public Schools to obtain any necessary medical care they deem necessary including, but not limited to, obtaining paramedic assistance and transport to a local hospital for additional treatment or observation.

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

I have read the Vaccine Information Sheet(s) and have had a chance to ask questions. The risks and benefits have been explained to me. 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.

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

I authorize Total Health Care, Inc. to collect and enter my child's immunization records into the Maryland's Immunization Information System (Immunet). Immunet is a confidential, computer system that contains immunization records. I understand that information in the registry may be released to a public health agency as well as my healthcare providers to assist in my child's medical care. In addition, information may be released to childcare 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 my local health department.

The above information is true to the best of my knowledge.

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