HEMATITE HEALTH CLINIC
IMMUNIZATION QUESTIONNAIRE AND CONSENT FORM

According to the Michigan Care Improvement Registry (MCIR) records, _____ needs the immunizations highlighted in the following table.

Please fill out the parent consent/immunization questionnaire **on the back of this form**-it must be completed **prior** to your child receiving services. Once we have received the signed parent consent/immunization questionnaire form we will then schedule an appointment for your child.

If you have documentation showing that your child has received the vaccination(s), please provide us with that documentation and we will be happy to update his/her record within the state system.

Please initial the boxes below indicating the vaccine(s) you wish to consent to or decline for your child.

Vaccine due	Vaccine:	Consent	Decline	Reason for Refusal:
	Tetanus Diphtheria Pertussis (Tdap)			
	Measles Mumps Rubella (MMR) series*			
	Varicella (chicken pox) Series*			
	Seasonal Influenza			
	Hepatitis B series*			
	Hepatitis A series*			
	Meningococcal series*			
	MenB series*			
	Human Papilloma Virus (HPV) series*			
	Updated mRNA COVID-19 Vaccine			

**** Please Note: By giving consent to a vaccine that is part of a series, I am giving my consent for the administration of all vaccines needed as part of the series.***

I have been given a copy and have read, or have had explained to me, the information contained on the appropriate Vaccine Information Statement (VIS) about the disease(s) and the vaccine(s) which are due today. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the specific vaccine(s) and I ask that the vaccine(s) series indicated above be given to the person named above for whom I am authorized to make this request, and I ask that the administration of the vaccine(s) be recorded in the MCIR. I understand the possible consequences of not allowing my child to receive the recommended vaccination may include contracting the illness the vaccine is intended to prevent and transmitting the disease to others.

Parent/Guardian Signature: _____ Date: _____
Print/Sign

Form Reviewed by: _____ Date:_____
Print/Sign

OVER →

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Age-appropriate immunizations are provided to children and adults subject to availability of vaccines, and in accordance with policies of the Michigan Department of Health and Human Services and this clinic.

Thank you for coming to our clinic. Information on person to be immunized:

Patient Name: **Date of birth:** **Age:** **Sex: M ☐ F☐**

Do you have insurance?	Yes ☐	No ☐	If yes, does it cover immunization?	Yes ☐	No ☐
Are you currently on Medicaid?	Yes ☐	No ☐	If yes, please present Medicaid card to receptionist.		
Are you currently on Medicare?	Yes ☐	No ☐	If yes, please present Medicare card to receptionist.		
Are you American Indian?	Yes ☐	No ☐	Are you Alaskan Native?	Yes ☐	No ☐
Are you on MI-Child?	Yes ☐	No ☐			

Screening Questionnaire for Child and Teen Immunization

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer yes to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.	**YES**	**NO**	**Don't Know**
1. Is the 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. Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?			
4. If the child to be vaccinated is between the ages of 2 and 4 years, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?			
5. If your child is a baby, have you ever been told he or she has had intussusception?			
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?			
8. Does the child have cancer, leukemia, AIDS, or any other immune system problem?			
9. In the past 3 months, has the child taken cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?			
10. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?			
11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?			
12. Has the child received vaccinations in the past 4 weeks?			

T0 BE COMPLETED BY HEMATITE HEALTH CLINIC STAFF ONLY:

Site:	Vaccine:	Lot#	Nurse Staff:	Date of Vaccination:
RD LD				
RD LD				
RD LD				
RD LD				
RD LD				
RD LD				