

NAME:				
Last	First	MI	Birthday	Age
ADDRESS:				
Street			Phone	
City			State	Zip
<p>“I have read or have had explained to me the Information in the Vaccine Information Statement (VIS) about the vaccine(s) that will be administered. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) checked below be given to me or to the person named above for whom I am authorized to make this request.”</p> <p>In accordance with NOPP regulations: (please initial appropriate line)</p> <p>_____ I authorize MCHD to send my child’s immunization record to my physician _____.</p> <p>_____ I authorize MCHD to send my child’s immunization record to _____ School District.</p> <p>_____ I have been informed about the HIPAA Information</p> <p>Signature of person to receive vaccine or person authorized to make request (Must be over 18).</p> <p>X _____ Date: _____</p>				

Wasted Vaccine

Childhood Vaccine

Vaccine Administration Record

Vaccine	Dose #	Date Given	Manufacturer	Lot Number	Injection site	VIS
Pentacel						5/17/07,11/8/11,12/16/98
Hepatitis B						2/2/12
Rotarix						12/6/10
Prevnar						4/16/10
MMR						4/20/12
Varicella						3/13/08
Hib						12/16/98
Dtap						5/17/07
Hepatitis A						10/25/11
Kinrix						11/8/11, 5/17/07
Tdap						1/24/12
HPV (Gardasil)						2/22/12
Meningococcal						10/14/11
Flu						7/2/12
Pediarix						5/17/07, 11/8/11, 2/2/12

Signature of Vaccine Administrator _____

RN

Hillsboro/Litchfield/Clinic

Revised 1/24/13

Public Aid

VIS Forms reviewed/given _____

Date _____

CLINIC CONTRAINDICATION CHECKLIST

Name of Recipient _____ D/O/B _____ M F

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Is the child sick with something more than just a cold? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Is the child running a fever? Temperature _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Does the child have any type of rash? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has the child received an immunization within the last six (6) weeks? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Does the child have cancer, leukemia or lymphoma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Does the child have a disease that lowers the body's resistance to infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Is the child taking drugs that lowers the body's resistance to infection, such as cortisone or prednisone. | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Does the child live in the same household with anyone who has a condition that lowers the body's resistance to infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Is the child pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Is the child allergic to an antibiotic called neomycin or streptomycin? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has the child received gamma globulin or a blood transfusion within the preceding five (5) months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Does the child have convulsions or other neurologic problems, or has a parent, brother, sister ever has a convulsion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Has the child ever experienced a temperature of 105 degrees or greater after receiving an immunization? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Has the child experienced total collapse (not fainting) or shock following a vaccination? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Has the child ever had persistent screaming episodes of three (3) hours or longer following an immunization? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. I am aware and understand the other possible side effects, found on the Importance Information forms, that could be caused from the vaccine(s). | <input type="checkbox"/> | <input type="checkbox"/> |

I have read, understand and have had an opportunity to ask questions concerning the above information and agree to remain in the clinic area for six (6) minutes after the vaccine (s) is/are administered.

Doctor's Name _____

Doctor's Address _____

Parent/Legal Guardian (PRINT) _____

Home Address _____

Parent/Legal Guardian Signature _____ Date _____

If the answer to #16 is no, consult with a nurse before immunizations are given.

SIGNATURE OF NURSE _____

CORNERSTONE INFORMED CONSENT FORM

Name of Participant: _____
(Last) (First) (M)

Date of Birth: _____ Male _____ Female _____
(Month) (Day) (Year)

Participant's ID Number _____

It is important that you read the following. If there is anything that you do not understand, or if you have any questions, be sure to ASK.

Welcome to Cornerstone, a system that collects data on a wide range of health care services to individuals. These services include WIC (Women, Infants and Children); Immunizations; Case Management; Prenatal and Postpartum Care; Pediatric Primary Care; Early Intervention; Breast and Cervical Cancer; Diabetes Control; Healthy Families Illinois; and Family Health History Questionnaire / Genetics.

We are asking for permission to collect information about the participant and store it in a centralized computer system maintained by the Illinois Departments of Human Services and Public Health. Based on the information collected during the enrollment or registration process, we will determine whether you need further service. Only those authorized health care professionals with a direct need to know about you will have access to this information. Information may be released for service authorization, audit, and evaluation purposes. Necessary information, without any client's name, will be sent to federal agencies that fund these programs.

By signing this consent form, you agree to allow certain information to be collected by this agency/clinic. The person(s) receiving this information has a legal and ethical duty to keep the information confidential and private, and not release it to anyone else without your written permission unless the law allows it.

- A. I authorize _____ (Cornerstone site) to collect information during the enrollment/registration process.
- B. This authorization covers all the medical, social and financial information about the participant, including: participant background and demographic information; health visit information; medical and developmental history; prenatal, birth, and postpartum data; infant/child visit data; immunization records; participant risks; problems or factors that prevent the participant from receiving proper medical care; appointments made and services received; goals and care plan; WIC food packages; program information; information required by the federal Maternal and Child Health Block Grant Program, and Early Intervention. Any information you do not want released should be written in Part D.
- C. This authorization also covers information about mental health, AIDS, HIV, sexually transmissible diseases, alcoholism, and drug use which may be reported by me. I understand that I am not required to report or discuss those matters with anybody.
- D. The following information I do NOT want to be shared:
- E. I am making this consent within the limits of my legal authority. I understand that I may revoke this consent orally or in writing at any time, but that revoking this consent will not cancel what was done before I revoked it. I also understand and agree not to hold the Illinois Departments of Human Services and Public Health liable for the release of any information about me in accordance with the terms of this consent form.
- F. A photostatic copy/facsimile of this consent will be as valid as the original

For child participant:

For adult participant:

Signature of parent/legal guardian/caretaker/**Date**

OR

Signature of adult participant/**Date**

Signature of Witness: _____

Date:

