FRANKLIN-WILLIAMSON BI-COUNTY HEALTH DEPARTMENT
Immunization Contraindication Checklist

NAME OF RECIPIENT:_____ BIRTHDATE:_____

1.	Does the client have a current Public Aid Medical Card?..... If "Yes", please present current medical card to receptionist.	Y	N
3.	Is the client sick (with an illness other than a cold)?.....	Y	N
4.	Has client had a fever of over 100° or greater during the last 24 hours?.....	Y	N
5.	Has client received an immunization within the last 30 days or a TB skin test within the last 3 days?.....	Y	N
6.	Does the client have a disease that lowers the body's resistance to infections, such as leukemia, lymphoma, generalized malignancy or AIDS?.....	Y	N
7.	Is client being treated with drugs/medication, such as cortisone or prednisone, chemotherapy or radiation, that lowers the body's resistance to infections?.....	Y	N
8.	Does the client live in the same household with anyone who has a condition that lowers the body's resistance to infection?.....	Y	N
9.	Is the client allergic to a gelatin product, streptomycin, neomycin, gentamicin, tobramycin, amikacin, amphotericin B, eggs, yeast, or monosodium glutamate?.....	Y	N
10.	Has client had a blood or plasma transfusion or received immune globulin within the last 5 months?.....	Y	N
11.	Has the client ever had convulsions or other problems of the nervous system?.....	Y	N
12.	Is the client pregnant or planning pregnancy within the next 3 months?.....	Y	N
13.	If child is receiving chickenpox vaccine, is there a pregnant household member?.....	Y	N
14.	Has the client ever had a reaction to a previous immunization such as fever greater than 105°, convulsions or seizures, total collapse or shock, a high pitched cry or screaming episode lasting 3 hours or more, severe itching rash or anaphylactic allergic reaction?.....	Y	N
15.	Has the client ever had a serious reaction to a product containing Thimerosal (a mercurial antiseptic)?.....	Y	N

CONSENT AND AUTHORIZATION:
I have read or had explained to me the Vaccine Information Statement for the Vaccines received today and understand the risks and benefits. I GIVE CONSENT to FWBCHD to vaccinate the person listed at the top of this form.

Signature of Responsible Party:_____ Date:_____

Relationship to Recipient:_____
(MUST BE PARENT, LEGAL GUARDIAN, OR CARETAKER IF UNDER 18)

(OFFICE USE ONLY)

Infant Multi Dose	MEN B			PPV-23
DTaP	IPV	HIB	Hep B	PCV-13
TD	Tdap	Varicella	MMR	Rotavirus
HPV	Shingles	Hep A	Meningococcal	MMRV

CHIP ☐ **VFC/STATE** ☐ **P/P** ☐ **VFA** ☐

Nurse reviewing the form & Administering Vaccine:_____ Date:_____

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8160 Express Drive
Marion, IL 62959-9808
Phone 618/993-8111
Fax 618/993-6455

FRANKLIN-WILLIAMSON
BI-COUNTY
HEALTH DEPARTMENT
www.bicountyhealth.org

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403 East Park
Benton, IL 62812-1920
Phone 618/439-0951
Fax 618/438-3005

HIPAA Compliance Patient Consent Form

Our notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/ date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The Health Department reserves the right to change the privacy policy as allowed by law.
- The Health Department has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The Health Department may condition receipt of treatment upon execution of this consent.

_____(PRINT CLIENT NAME)

This consent was signed by:_____(PRINT NAME PLEASE)

Signature of Client/ Guardian:_____Date:_____

Witness:_____ Date:_____