



Permission for Immunizations to be given by Shiawassee County Health Department

Date:

I _____ give permission to _____
(Parent Name) (Individual bringing child)
to bring my child _____ to receive immunizations.
(Child's name)

Screening Questionnaire for Child and Teen Immunization

For parents/guardians: Please mark yes or no for the following questions, which will help us determine which vaccines your child may receive. Please also complete second page.

1. Is the child sick today? Yes ☐ No ☐
2. Does the child have allergies to medications, food, or any vaccine? Yes ☐ No ☐
3. Has the child had a serious reaction to a vaccine in the past? Yes ☐ No ☐
4. Has the child had a health problem with asthma, lung disease, heart disease, kidney disease, metabolic disease (e.g., diabetes), or a blood disorder? Yes ☐ No ☐
5. If the child 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? Yes ☐ No ☐
6. Has the child had a seizure, brain, or other nervous system problem? Yes ☐ No ☐
7. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem? Yes ☐ No ☐
8. Has the child taken cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments in the past 3 months? Yes ☐ No ☐
9. Has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug in the past year? Yes ☐ No ☐
10. Is the child/teen pregnant or is there a chance she could become pregnant during the next month? Yes ☐ No ☐
11. Has the child received vaccinations in the past 4 weeks? Yes ☐ No ☐
12. Please describe any yes responses to questions above.

13. Is there anything else that you would like us to know about your child?

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The Vaccine Information Statements (VIS) and/or the VIS QR Code forms may be given to the person with the child when immunizations are given? Yes ☐ No ☐

Please check which vaccines are to be given:

☐ Age-appropriate vaccines

☐ Seasonal flu vaccine

☐ Seasonal Covid-19

☐ School required vaccines only

☐ Only the following specified vaccines

Please complete the following for the child receiving immunizations.

Name _____
(Last) (First) (Middle Initial)

Birthdate _____ Age _____

Address _____

Signature of Parent/guardian

X _____

Date:

Phone number where parent/guardian can be reached _____

MDHHS-6310, MICHIGAN CARE IMPROVEMENT REGISTRY (MCIR) IMMUNIZATION NOTICE

Michigan Department of Health and Human Services (MDHHS)
Division of Immunization
(Revised 3-26)

The Michigan Care Improvement Registry (MCIR) provides a place for your or your child's immunization history to be stored confidentially. MCIR is used as a tool and can help providers accurately determine if a vaccine is needed based on the recorded immunization history. MCIR collects and combines immunization information for Michigan residents of all ages. Information in MCIR is confidential and all MCIR users are held to strict security and confidentiality requirements.

Having immunization data in MCIR can:

- Prevent harmful delays in medical care.
- Prevent over or under vaccination for a person (i.e. missing a vaccine or getting a repeated dose).
- Reduce healthcare burden by providing an accurate immunization history for providers to base their recommendations.

You have the right to object to having your or your child's immunization(s) reported to MCIR, which is otherwise required by [MCL 333.9209](#). Remember, if immunization information is not stored in MCIR, your provider might not have access to a complete immunization history, and it will be essential for you to keep your and/or your child's immunization record for future medical visits, schooling or possible employment opportunities.

An immunization history can be printed by a healthcare provider. For those 18 years or older, you can print your immunization record yourself from the secure [MCIR Public Portal](#).

By signing this form, I acknowledge that I have received the form.

Signature	Date

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.