NEBRASKA
Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

NEBRASKA IMMUNIZATION ADMINSTRATION PROXY FORM

I have been given a copy and have read or have had explained to me the information in the "Vaccine Information Statement(s) for the vaccine(s) checked below. I have had the chance to ask questions and have had them answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and request that they be given to the person named below *for whom I am parent or legal guardian.*

_____Tetanus/Diptheria/Acellular Pertussis (Tdap)
_____Tetanus/Diptheria (Td)
_____Hepatitis A (Hep A)
_____Hepatitis B (Hep B)
_____Meningococcal (MCV)
_____Human Papilloma (HPV)
_____Meningitis B
_____Rotavirus (RV)
_____Diptheria/Tetanus/ Acellular Pertussis (DTaP)
_____Pneumococcal Conjugate (PCV-13)
_____Haemophilus Influenza B (HIB)
_____Varicella (Var/VZV)
_____Measles/Mumps/Rubella (MMR)
_____DTaP/IPV/HIB (Pentacel)
_____DTaP/IPV/Hepatitis B (Pediarix)
_____Influenza
_____Dtap/IPV (Kinrix)
_____Polio (IPV)
_____ Other _____

INFORMATION ABOUT THE PERSON **RECEIVING** THE IMMUNIZATION ***(PLEASE PRINT)**

REQUIRED in order for us to immunize your student: A ***copy of your insurance card*** (front and back) and ***answer the following questions as well as the questionnaire on the back of this page.***

Name: Last	**First**	**Middle**	**Birthdate** ___/___/_____	**Age**

Address: Street	**City**	**County**	**State**	**Zip**

Insurance *Circle one:*	Blue Cross Blue Shield Aetna Molina Nebraska Total Care United Health Care Community Plan Other _____ Uninsured or *Underinsured

Insurance Policy Holder's Date of Birth and Social Security #

DOB _____/_____/_____ **SSN** _____

Signature of Parent or Legal Guardian **X**	**Date** ___/___/_____

***Underinsured: Patients insurance does not cover immunizations.**

This proxy form is valid for only TWO WEEKS from date of parent signature.

Parent/Guardian Phone Number ****In case the nurse has any questions regarding your form****	

LoupBasin
PUBLIC HEALTH DEPARTMENT

Screening Checklist for Contraindications to Vaccines for Children and Teens

PATIENT NAME _____

DATE OF BIRTH ____/____/____ (month / day / year)

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 medicine, food, a vaccine component, or latex?	☐	☐	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Does the child have a long-term health problem with heart, lung (including asthma), kidney, liver, nervous system, or metabolic disease (e.g., diabetes), a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are they taking regular aspirin or salicylate medication?	☐	☐	☐
5. For children age 2 through 4 years: Has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐	☐	☐
6. For babies: Have you ever been told the child had intussusception?	☐	☐	☐
7. Has the child, a sibling, or a parent had a seizure; has the child had a brain or other nervous system problem?	☐	☐	☐
8. Has the 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?	☐	☐	☐
9. Does the child have an immune-system problem such as cancer, leukemia, HIV/AIDS?	☐	☐	☐
10. In the past 6 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs to treat rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	☐	☐	☐
11. Does the child's parent or sibling have an immune system problem?	☐	☐	☐
12. In the past year, has the child received immune (gamma) globulin, blood/blood products, or an antiviral drug?	☐	☐	☐
13. Is the child/teen pregnant?	☐	☐	☐
14. Has the child received vaccinations in the past 4 weeks?	☐	☐	☐
15. Has the child ever felt dizzy or faint before, during, or after a shot?	☐	☐	☐
16. Is the child anxious about getting a shot today?	☐	☐	☐

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

Did you bring your immunization record card with you? **yes** ☐ **no** ☐

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.