ALL SERVICES PROVIDED ON A NON DISCRIMINATORY BASIS

Livingston County Health Center

Immunization Consent and History - CHILD

Livingston County Health Center
800 Adam Drive Chillicothe, MO 64601

Please fill out the following information for the person being vaccinated.

Last Name	First Name	__M __F	Date of Birth ______/______/_____

Street Address City State	Zip Code	Phone:

School attending and Grade ________________________or Daycare Provider ______________________________

Authorization to Vaccinate

I have been given a copy of and have read, or had explained to me, the information in the **"Vaccine Information Statements"** for the vaccines indicated below. I understand the benefits and risks of the vaccines and ask that the vaccines be given to me or the person named above for whom I am the authorized to make this request pursuant to Section 431.058,RSMo.

X____

Authorized Signature (Parent/Legal guardian) Relationship to above Date

How would you like to be notified of scheduled appointments?

☐**Text Message (Cell#)** ________________ ☐**Email** ______________________ ☐**Postal Mail**

Vaccine Information Statements

☐ Dtap/DT 5-17-07 ☐ Tdap 02-24-15 ☐ HPV 12-2-2016 ☐ Hep B 07-20-2016 ☐ Hep A 07-20-2016

☐ Polio 07-20-2016 ☐ MMR 04-20-12 ☐ Multi 11-5-15 ☐ Men B 08-09-2016

☐ Varicella 3-13-08 ☐ Hib 4-2-15 ☐ Prevnar13 11-5-15 ☐ Rotavirus 4-15-15 ☐ MMRV 05-21-10

☐ MCV4/MPSV4 3-31-16 ☐ Influenza 8-07-15

Race		Ethnicity	
___White	___Black	___Non-Hispanic	____Cuban
___Alaskan/Native American	___Asian	____Mexican	____Central/South American
___Hawaiian or Pacific Islander	___Hispanic/Latino	____Puerto Rican	____Other
___Bi Racial or Multi Racial			

Insurance Information

__ MoHealth/Medicaid ___No Insurance ___ Private Insurance(such as BCBS, CIGNA, etc)

Form completed by: **(PLEASE PRINT)**

____Relationship _____________________Date______________________

It is important to have a personal record of your vaccinations. If you do not have a record card, ask the nurse to give you one. Bring this record with you every time you seek medical care. Make sure your health provider records all your vaccinations on it

Modified 12-2017

"If you would like a copy of our NOPP (Notice of Privacy Policy), please let us know."

Child's Name and Date of Birth ____

	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 problems with lung, heart, kidney or metabolic disease (e.g. diabetes), asthma, or a blood disorder? Is he/she on long term aspirin therapy?	☐	☐	☐
5. 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 a wheezing or asthma in the last 12 months?	☐	☐	☐
6. If your child is a baby, have you ever been told he or she has intussusceptions?	☐	☐	☐
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, HIV/AIDS, or any other immune problem?	☐	☐	☐
9. In the past 3 months has the child taken medications that weaken the immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments? or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
10. In the past year has the child received a transfusion of blood or blood products or been given immune (gamme) 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 four weeks?	☐	☐	☐

Pentacel/Pediarix	Dtap/Tdap/Kinrix	Meningitis
Mfr/Lot Exp Date	Mfr/Lot Exp Date	Mfr/Lot Exp Date
Site Initials	Site Initials	Site Initials
HIB	PREVNAR 13 (Pneumoccal Conjugate)	HEPATITIS A
Mfr/Lot Exp Date	Mfr/Lot Exp Date	Mfr/Lot Exp Date
Site Initials	Site Initials	Site Initials
HEPATITIS B	MMR	VARICELLA
Mfr/Lot Exp Date	Mfr/Lot Exp Date	Mfr/Lot Exp Date
Site Initials	Site Initials	Site Initials
ROTAVIRUS	IPV	OTHER:
Mfr/Lot Exp Date	Mfr/Lot Exp Date	Mfr/Lot Exp Date
Site Initials	Site Initials	Site Initials

Signature and Title of Vaccine Administrator	Date Administered and VIS Given
Signature and Title of Vaccine Administrator	Date Administered and VIS Given