

ALL SERVICES PROVIDED ON A NON DISCRIMINATORY BASIS

**Livingston County Health Center
Immunization Consent and History**

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	<u> </u> M <u> </u> F	SS# ____-____-____	Date of Birth ____/____/____
Street Address	City	State	Zip Code	Phone:

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 (client if over age 18, or Parent/Legal guardian) Relationship to above Date

Vaccine Information Statements

- Dtap/DT 5-17-07 Tdap/Td 11-18-08 HPV 5-03-2011 Hep B 7-18-07 Hep A 10-25-11
 Meningitis 10-14-2011 Polio 11-8-11 MMR 3-13-08 Multi Vaccine 9-18-08 Influenza 7-26-11
 Varicella 3-13-08 Hib 12-16-98 Prevnar 4-16-2010 Rotavirus 12-06-2010

~~For Clinic Use Only—To be filled in by Nursing Staff~~

Comments: Number of vaccines given per parent/guardian request No immunization record Refer to FQHC (Non-VFC)

DTaP/Hib/IPV (Pentacel)		Dtap/Tdap/Kinrix		Meningitis	
Mfr/Lot	Exp Date	Mfr/Lot	Exp Date	Mfr/Lot	Exp Date
Site	Initials	Site	Initials	Site	Initials
HIB		PREVNAR (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

Screening Questionnaire For Infant and Child Immunization

Please Check All That Apply

Medicaid Uninsured Private Insurance

If you have private insurance does it pay for immunizations? Yes No Don't Know

Race	Ethnicity
<input type="checkbox"/> White <input type="checkbox"/> Alaskan/Native American <input type="checkbox"/> Hawaiian or Pacific Islander <input type="checkbox"/> Bi Racial or Multi Racial	<input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-hispanic <input type="checkbox"/> Mexican <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Central/South American <input type="checkbox"/> Other <input type="checkbox"/> Unknown

The following questions will help us determine which vaccines may be given today.
 If a question is not clear, please ask the nurse to explain it.

	Yes	No	Don't Know
1. Is the child sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the child have allergies to medications, food, a vaccine component, or latex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the child had a serious reaction to a vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems??	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Does the child have cancer, leukemia, AIDS, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. In the past 3 months, has the child taken cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Has the child received vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Child's Daycare Provider or School _____			

Form completed by: (PLEASE PRINT) _____

_____ Relationship _____ Date _____

It is important to have a personal record of your child's immunizations. 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 for your child. Make sure your health provider records all your child's vaccinations. Your child will need this to enter daycare and school.