ADULT

IMMUNIZATION CONSENT AND HISTORY

Livingston County Health Center
800 Adam Drive Chillicothe, MO 64601

Last Name	First Name	MI	Male/Female	Date of Birth

Street Address	City	State	Zip Code	Phone	Age

Insurance Information

______ **Medicare*** ______ **MoHealth/Medicaid** ______ **Private Insurance** ______ **I Am Uninsured**

Does your insurance pay for vaccinations? _____ No _____Yes

***Medicare Number:** ____

I authorize payment of Medicare claim to the Livingston County Health Center; and release of medical information to process this claim.

____

Signature **Date**

Race

☐ White
☐ Black
☐ Alaskan/Native American
☐ Asian
☐ Hawaiian/Pacific Islander
☐ Hispanic/Latino
☐ Bi Racial or Multi Racial

Ethnicity

☐ Non-Hispanic
☐ Cuban
☐ Mexican
☐ Central/South American
☐ Puerto Rican
☐ Other

Vaccine Information Statements

☐ Tdap 02-24-2015
☐ Td 04-11-2017
☐ Influenza 8-15-2019
☐ Influenza (Live) 8-15-2019
☐ Hepatitis A 07-20-2016
☐ Varicella 8-15-19
☐ MenACWY 8-15-2019
☐ HPV 12-02-2016
☐ Hepatitis B 08-15-19
☐ MMR 08-15-19
☐ Pneumo23 4-24-15
☐ Zoster 02-12-2018
☐ Prevnar13 11-5-15
☐ MenB 08-15-2019

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 above. 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.

____

Signature **Date**

MODIFIED 09-2019 "IF YOU WOULD LIKE A COPY OF OUR NOPP (NOTICE OF PRIVACY POLICY), PLEASE LET US KNOW."

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME ______________________________

DATE OF BIRTH _______ / _______ / _________
MONTH DAY YEAR

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask a nurse to explain it.

		yes	no	don't know
1.	Are you sick today?	☐	☐	☐
2.	Do you have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3.	Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4.	Do you have a long-term health problem with heart, lung, kidney or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, cochlear implant, or spinal fluid leak? Are you on long term aspirin therapy?	☐	☐	☐
5.	Do you have cancer, leukemia, HIV/AIDS or any other immune system problem?	☐	☐	☐
6.	Do you have a parent, brother or sister with an immune system problem?	☐	☐	☐
7.	In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	☐	☐	☐
8.	Have you had a seizure or a brain or other nervous system problem?	☐	☐	☐
9.	During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
10.	For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
11.	Have you received any vaccinations in the past 4 weeks?	☐	☐	☐

FORM COMPLETED BY: (PLEASE PRINT) ______________________________ DATE ____________________

To Be Completed By Nursing Staff

VACCINE:	VACCINE:	VACCINE:
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

ALL SERVICES PROVIDED ON A NON DISCRIMINATORY BASIS