

**Livingston County Health Center
 Immunization Consent and History - Adults aged 19 +**

Livingston County Health Center
 800 Adam Drive Chillicothe, MO 64601
 Phone: 660-646-5506 Fax: 660-646-4485

ALL SERVICES PROVIDED ON A NON DISCRIMINATORY BASIS

Last Name	First Name	MI	<input type="checkbox"/> M <input type="checkbox"/> F	SS No. - - - - -	Date of Birth / / - - - -
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STREET ADDRESS	CITY	STATE	ZIP CODE	PHONE
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Insurance Information

MoHealth/Medicaid Uninsured Private Insurance

Does your insurance pay for vaccinations? NO Yes.

If you are age 65 or older please fill out the following information:

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

Signature _____ Date _____

My Medicare number is _____.

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

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 Relationship Date

Vaccine Information Statements

- Tdap 02-24-2015 Hepatitis A 07-20-2016 Hepatitis B 07-20-2016 Shingles 10-6-09
 Td 04-11-2017 Varicella 3-13-08 MMR 4-20-12 Pneumococcal 4-24-15 Prevnar13 11-5-15
 Influenza 8-7-2015 MCV4/MPSV4 3-31-2016 HPV 12-02-2016 MenB 08-14-2015

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

Screening Questionnaire For Adult Immunizations

- | | Yes | No | Don't Know |
|--|--------------------------|--------------------------|--------------------------|
| 1. Are you sick today? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have any allergies to medications, food, a vaccine component or latex? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had a serious reaction to a vaccine in the past? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have cancer, leukemia, AIDS or any other immune system problem? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. 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 have you had radiation treatments. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you had a seizure or a brain or other nervous system problem? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. During the past year, have you 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"/> |
| 9. For women: Are you pregnant or is there a chance you could become pregnant during the next month? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you received any vaccinations in the past four weeks? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Form completed by: (PLEASE PRINT)

X _____ Date _____

~ **The following information is to be completed by the 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

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