

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	<u> </u> M <u> </u> F	SS# ____-____-____	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 upcoming appointments?

Text Message (Cell#) _____ **Email** _____ **Postal Mail**

Vaccine Information Statements

- | | | | | |
|---|--|--|--|---|
| <input type="checkbox"/> Dtap/DT 5-17-07 | <input type="checkbox"/> Tdap 02-24-15 | <input type="checkbox"/> Gardasil 3-31-16 | <input type="checkbox"/> Hep B 07-20-2016 | <input type="checkbox"/> Hep A 07-20-2016 |
| <input type="checkbox"/> Polio 07-20-2016 | <input type="checkbox"/> MMR 04-20-12 | <input type="checkbox"/> Multi 11-5-15 | <input type="checkbox"/> Men B 08-14-15 | |
| <input type="checkbox"/> Varicella 3-13-08 | <input type="checkbox"/> Hib 4-2-15 | <input type="checkbox"/> Prevnar13 11-5-15 | <input type="checkbox"/> Rotavirus 4-15-15 | <input type="checkbox"/> MMRV 05-21-10 |
| <input type="checkbox"/> MCV4/MPSV4 3-31-16 | | <input type="checkbox"/> Influenza 8-07-15 | | |

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

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

Child's Name and Date of Birth _____

- | | 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. If your child is a baby, have you ever been told he or she has intussusceptions? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. 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"/> |
| 8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune problem? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. 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"/> |
| 12. Has the child received vaccinations in the past four weeks? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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
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