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	__M __F	SS No. _____-____-_____	Date of Birth _____/_____/_____

STREET ADDRESS	CITY	STATE	ZIP CODE	PHONE	Age

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
___White ___Black/African American ___Alaskan/Native American ___Asian ___Hawaiian or Pacific Islander ___Hispanic/Latino ___Bi or Multi Racial	____Non-hispanic ____Cuban ____Mexican ____Central/South American ____Puerto Rican ____Other ____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 10-12-18 ☐ Zoster 02-12-2018

☐ Td 04-11-2017 ☐Varicella 2-12-18 ☐ MMR 4-20-12 ☐ Pneumo23 4-24-15 ☐ Prevnar13 11-5-15

☐ Influenza 8-7-2015 ☐ MenACWY 8-24-2018 ☐ HPV 12-02-2016 ☐ MenB 08-19-2016

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

Modified 10-2018

Screening Questionnaire For Adult Immunizations

	Yes	No	Don't Know
1. Are you sick today?	☐	☐	☐
2. Do you have any allergies to medications, food, a vaccine component or latex?	☐	☐	☐
3. Have you ever had a serious reaction to a vaccine in the past?	☐	☐	☐
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?	☐	☐	☐
5. Do you have cancer, leukemia, AIDS or any other immune system problem?	☐	☐	☐
6. In the past 3 months have you taken medications that affect your immunine 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.	☐	☐	☐
7. Have you had a seizure or a brain or other nervous system problem?	☐	☐	☐
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?	☐	☐	☐
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
10. Have you received any vaccinations in the past four weeks?	☐	☐	☐

Form completed by: (PLEASE PRINT)

X_____Date_____

~ The following information is to be completed by the nursing staff. ~

VACC INE:		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