CHILD

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

Form Completed By (Please Print)

Insurance Information

_____ **MoHealth/Medicaid** _____ **Private Insurance** _____ **No Insurance**

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

☐ Dtap/DT 8-24-18
☐ Tdap 02-24-15
☐ HPV 12-02-16
☐ Hep B 08-15-19
☐ Polio 07-20-16
☐ MMR 08-15-19
☐ Multi 11-05-15
☐ Hep A 07-20-16
☐ Varicella 08-15-19
☐ HIB 04-02-15
☐ Prevnar 13 11-05-15
☐ MenB 08-15-2019
☐ MCV4/MPSV4 08-15-19
☐ Influenza 08-15-19
☐ MMRV 08-15-19
☐ Rotavirus 02-23-18
☐ Influenza(LIVE) 08-15-19

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**

ALL SERVICES PROVIDED ON A NON DISCRIMINATORY BASIS

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 Children & Teens

PATIENT NAME_____ ____

DATE OF BIRTH _____ / _____ / _____
MONTH DAY YEAR

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

		yes	no	don't know
1.	Is the child sick today?	☐	☐	☐
2.	Does the child have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3.	Has the child ever had a serious reaction to a vaccine in the past?	☐	☐	☐
4.	Does the child 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.	If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you the child had wheezing or asthma in the past 12 months?	☐	☐	☐
6.	If your child is a baby, have you ever been told he or she has intussusception?	☐	☐	☐
7.	Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐	☐	☐
8.	Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
9.	Does the child have a parent, brother or sister with an immune system problem?	☐	☐	☐
10.	In the past 3 months, has the child taken medications that affect the 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?	☐	☐	☐
11.	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?	☐	☐	☐
12.	Is the child pregnant or is there a chance she could become pregnant during the next month?	☐	☐	☐
13.	Has the child received vaccinations in the past 4 weeks?	☐	☐	☐

VACCINE:	**VACCINE:**	**VACCINE:**
MFR/LOT EXP DATE	MFR/LOT EXP DATE	MFR/LOT EXP DATE
SITE INITIALS	SITE INITIALS	SITE INITIALS
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**

Signature and Title of Vaccine Administrator **Date Administered and VIS Given**