##  Ray County Health Department

##  820 E. Lexington Street

##  Richmond, MO 64085

 **PHONE: 816-776-5413**

##  immunization consent form

|  |
| --- |
| PATIENT INFORMATION |

|  |  |  |
| --- | --- | --- |
| Last Name: | First Name: | Middle: |
| Parent or Guardian Name/Relationship | Mother’s Maiden Name: | Patient Birth Date:  / / |
| Patient approximate Ht: | Approximate Wt: | Age: Sex: □ M □ F |
| Street Address: | City: | Patient Race: □White □ African American □Am. Indian □ Other□ Hispanic □ Non-Hispanic |
| State: | Zip Code: | Phone Number: |

|  |
| --- |
| Insurance Questionnaire |

|  |  |
| --- | --- |
| Is this patient covered by private insurance? | □ Yes □ No  |
| Is the patient covered by MoHealthnet? (Please provide your card) | □ Homestate □ UHC □ Healthy Blue |
| **(For clinic use only)** Medicaid □ Uninsured □ Private □Underinsured □ American Indian or Alaskan Native □ | **(For clinic use only)**Chip Dose □ Yes □ No Verified Date: \_\_\_\_\_\_\_\_\_\_\_\_\_eMOMED □ MOHSAIC □ EMR □DCN #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□ Homestate □ UHC □ Healthy Blue |

|  |
| --- |
|  Screening Questionnaire |
| Is the patient sick today? □ Yes □ No  |
| Has the patient been on any medications/antibiotics within the last two weeks? □ Yes □ NoList- |
| Does the patient have any allergies to latex, medications, food, or any vaccine? □ Yes □ NoIf Yes, Explain:  |
| Has the patient been exposed to any contagious diseases in the last 2-3 weeks? □ Yes □ No |
| Has the patient ever had a seizure? □Yes □ No Febrile seizure? □ Yes □ No |
| Has the patient had any adverse reactions to other immunizations? □ Yes □ No If Yes, Explain: |
| Has the patient received any other vaccinations in the past 4 weeks? □ Yes □ NoExplain: |
| **Administer fever reducing medication for at least 48 hours following immunizations.** |
| I have been given a copy and have read, or had explained to me, the information in the “Vaccine Information Statement(s)” for the vaccine(s) to be given. I acknowledge that this vaccination record will be kept in my medical file. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) be given to me or to the person named, for whom I am authorized to make this request.  |
|  | **X** |  |  |  |
|  | *Patient/Guardian signature* |  | *Date* |  |

**Services provided on a nondiscriminatory basis.**

 PT ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DCN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Provider Information: Ray County Health Department 820 E. Lexington Street Richmond, MO 64085 |
| FOR CLINICAL USE ONLY |
| VACCINE | DOSE | EXT | SITE | ROUTE |  LOT # | MFG.Intial | VISDATE | VISGIVEN |
| DTaP DT Td | 1 2 3 4 5 B | RTLT  | DeltoidVastus Lat | IM |  |  | 08/06/21 |  |
| Tdap | 1 | RTLT | DeltoidVastus Lat | IM |  |  | 08/06/21 |  |
| DTaP/HepB/EIPV(Pediarix) | 1 2 3 | RTLT | DeltoidVastus Lat | IM |  |  | 07/24/23 |  |
| DTaP/IPV/Hib/HepB(Vaxelis) | 1 2 3  | RTLT | DeltoidVastus Lat | IM |  |  | 07/24/23 |  |
| DTap/EIPV(Kinrix) | 4 5 | RTLT | DeltoidVastus Lat | IM |  |  | 07/24/23 |  |
| Hepatitis B(Ped/Adult) | 1 2 3 | RTLT | DeltoidVastus Lat | IM |  |  | 05/12/23 |  |
| Hib | 1 2 3 4 | RTLT | DeltoidVastus Lat | IM |  |  | 08/06/21 |  |
| EIPV (Polio) | 1 2 3 4 | RTLT | DeltoidVastus Lat | SQIM |  |  | 08/06/21 |  |
| PCV 20/ PCV 15 | 1 2 3 4 | RTLT | DeltoidVastus Lat | IM |  |  | 05/12/23 |  |
| RotavirusRotarix/Rotateq | 1 2 3 |  |  | Oral |  |  | 10/15/21 |  |
| MMR/Varicella(ProQuad) | 1 2 | RTLT | DeltoidVastus Lat | SQ |  |  | 08/06/21 |  |
| MMR | 1 2 | RTLT | DeltoidVastus Lat | SQ |  |  | 08/06/21 |  |
| Varicella | 1 2 | RTLT | DeltoidVastus Lat | SQ |  |  | 08/06/21 |  |
| Hepatitis A(Ped/Adult) | 1 2 | RTLT | DeltoidVastus Lat | IM |  |  | 10/15/21 |  |
| HPVGardasil 9 | 1 2 3 | RTLT | DeltoidVastus Lat | IM |  |  | 08/06/21 |  |
| MeningococcalMenQuadfi | 1 2  | RTLT | DeltoidVastus Lat | IM |  |  | 08/06/21 |  |
| MeningococcalMen B | 1 2  | RTLT | DeltoidVastus Lat | IM |  |  | 08/06/21 |  |
| Hep A/ Hep B(Twinrix)- Adult | 1 2 3 | RTLT | DeltoidVastus Lat | IM |  |  | 07/24/23 |  |
| Shingrix | 1 2 | RTLT | DeltoidVastus Lat | IM |  |  | 02/04/22 |  |

**Explain possible reactions to vaccine: □ Yes □ No**

**Temp.\_\_\_\_\_\_\_\_\_\_\_\_\_ Ear Exam: Rt.\_\_\_\_\_\_\_\_\_ Lt.\_\_\_\_\_\_\_\_\_\_ Nasal Exam:\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature and Title of Vaccine Administrator Date**