## Ray County Health Department

## 820 E. Lexington Street

## Richmond, MO 64085

**PHONE: 816-776-5413**

## immunization consent form

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| --- |
| 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 □ No  List- | | | | |
| Does the patient have any allergies to latex, medications, food, or any vaccine? □ Yes □ No  If 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 □ No  Explain: | | | | |
| **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 | VIS  DATE | VIS  GIVEN |
| DTaP DT Td | 1 2 3 4 5 B | RT  LT | Deltoid  Vastus Lat | IM |  |  | 08/06/21 |  |
| Tdap | 1 | RT  LT | Deltoid  Vastus Lat | IM |  |  | 08/06/21 |  |
| DTaP/HepB/EIPV  (Pediarix) | 1 2 3 | RT  LT | Deltoid  Vastus Lat | IM |  |  | 07/24/23 |  |
| DTaP/IPV/Hib/HepB  (Vaxelis) | 1 2 3 | RT  LT | Deltoid  Vastus Lat | IM |  |  | 07/24/23 |  |
| DTap/EIPV  (Kinrix) | 4 5 | RT  LT | Deltoid  Vastus Lat | IM |  |  | 07/24/23 |  |
| Hepatitis B  (Ped/Adult) | 1 2 3 | RT  LT | Deltoid  Vastus Lat | IM |  |  | 05/12/23 |  |
| Hib | 1 2 3 4 | RT  LT | Deltoid  Vastus Lat | IM |  |  | 08/06/21 |  |
| EIPV (Polio) | 1 2 3 4 | RT  LT | Deltoid  Vastus Lat | SQ  IM |  |  | 08/06/21 |  |
| PCV 20/ PCV 15 | 1 2 3 4 | RT  LT | Deltoid  Vastus Lat | IM |  |  | 05/12/23 |  |
| Rotavirus  Rotarix/Rotateq | 1 2 3 |  |  | Oral |  |  | 10/15/21 |  |
| MMR/Varicella  (ProQuad) | 1 2 | RT  LT | Deltoid  Vastus Lat | SQ |  |  | 08/06/21 |  |
| MMR | 1 2 | RT  LT | Deltoid  Vastus Lat | SQ |  |  | 08/06/21 |  |
| Varicella | 1 2 | RT  LT | Deltoid  Vastus Lat | SQ |  |  | 08/06/21 |  |
| Hepatitis A  (Ped/Adult) | 1 2 | RT  LT | Deltoid  Vastus Lat | IM |  |  | 10/15/21 |  |
| HPV  Gardasil 9 | 1 2 3 | RT  LT | Deltoid  Vastus Lat | IM |  |  | 08/06/21 |  |
| Meningococcal  MenQuadfi | 1 2 | RT  LT | Deltoid  Vastus Lat | IM |  |  | 08/06/21 |  |
| Meningococcal  Men B | 1 2 | RT  LT | Deltoid  Vastus Lat | IM |  |  | 08/06/21 |  |
| Hep A/ Hep B  (Twinrix)- Adult | 1 2 3 | RT  LT | Deltoid  Vastus Lat | IM |  |  | 07/24/23 |  |
| Shingrix | 1 2 | RT  LT | Deltoid  Vastus Lat | IM |  |  | 02/04/22 |  |

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

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

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**Signature and Title of Vaccine Administrator Date**