Ray County Health Department
820 E. Lexington Street
Richmond, MO 64085

MULTI-DOSE IMMUNIZATION CONSENT FORM

(Please Print)			Today's Date:
PATIENT INFORMATION			
Patient's Last Name:	First:	Middle:	Patient Birth Date: / /
			Age: Sex: ☐ M ☐ F
Parent/Guardian Name/ Relationship/ DOB	Mother's Maiden Name:		Patient Race: ☐White ☐ African American ☐Am. Indian ☐ Other
Patient approximate Ht:	Approximate Wt:		☐ Hispanic ☐ Non-Hispanic
Street Address:		Patient Social Security #:	Phone #: Home or Cell (Circle) ( )
P.O. Box:	City:	State:	ZIP Code:

INSURANCE INFORMATION

Is this patient covered by private insurance?	❑ Yes	❑ No		
Does your insurance cover immunizations?	❑ Yes	❑ No		
Is the patient covered by MoHealthnet? (Please show your insurance card to the receptionist.)	❑ Yes	❑ No	☐ Home State ☐ United Healthcare ☐ Missouri Care	
Name of secondary insurance (if applicable):				

SCREENING QUESTIONNAIRE

Is the patient sick today?	☐ Yes	☐ No
Has the patient been on any medications/antibiotics within the last two weeks? List-	☐ Yes	☐ No
Does the patient have any allergies to latex, medications, food, or any vaccine? If Yes, Explain:	☐ Yes	☐ No
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? If Yes, Explain:	☐ Yes	☐ No
Has the patient received any other vaccinations in the past 4 weeks? Explain:	☐ Yes	☐ No

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 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.

Name_____ DOB_____ PT ID:_____

DCN:_____

Provider Information					
Vaccine Provider: Ray County Health Department			Clinic Site:		
Street Address: 820 East Lexington Street	*State:* *MO*	Zip Code: 64085	Street Address:	State:	Zip Code:

(Circle the appropriate vaccine, dose, extremity, site, route, and enter the manufacturer, lot #, and expiration date)

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			04/01/20	
Tdap	1	RT LT	Deltoid Vastus Lat	IM			04/01/20	
DTaP/HepB/EIPV (Pediarix)	1 2 3	RT LT	Deltoid Vastus Lat	IM			04/01/20	
DTap/Hib/EIPV (Pentacel)	1 2 3 4	RT LT	Deltoid Vastus Lat	IM			04/01/20	
DTap/EIPV (Kinrix)	4 5	RT LT	Deltoid Vastus Lat	IM			04/01/20 10/30/19	
Hepatitis B (Ped/Adol)	1 2 3	RT LT	Deltoid Vastus Lat	IM			08/15/19	
Hib	1 2 3 4	RT LT	Deltoid Vastus Lat	IM			10/30/19	
EIPV (Polio)	1 2 3 4	RT LT	Deltoid Vastus Lat	SQ IM			10/30/19	
PCV 13 (Prevnar)	1 2 3 4	RT LT	Deltoid Vastus Lat	IM			10/30/19	
Rotavirus (Rotateq, Rotarix)	1 2 3			Oral			10/30/19	
MMR/Varicella (ProQuad)	1 2	RT LT	Deltoid Vastus Lat	SQ			08/15/19	
MMR	1 2	RT LT	Deltoid Vastus Lat	SQ			08/15/19	
Varicella	1 2	RT LT	Deltoid Vastus Lat	SQ			08/15/19	
Hepatitis A (Ped/Adol)	1 2	RT LT	Deltoid Vastus Lat	IM			07/28/20	
HPV Gardasil 9	1 2 3	RT LT	Deltoid Vastus Lat	IM			10/30/19	
Meningococcal MCV4	1 2	RT LT	Deltoid Vastus Lat	IM			08/15/19	
Meningococcal Men B	1 2 3	RT LT	Deltoid Vastus Lat	IM			08/15/19	
Hepatitis A (Adult)	1 2	RT LT	Deltoid Vastus Lat	IM			07/28/20	
Hepatitis B (Adult)	1 2 3	RT LT	Deltoid Vastus Lat	IM			08/15/19	
Hep A/ Hep B (Twinrix)-Adult	1 2 3	RT LT	Deltoid Vastus Lat	IM			07/28/20 08/15/19	

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

Temp._____ **Ear Exam: Rt.**_____**Lt.**_____ **Nasal Exam:**_____

_____ _____

Signature and Title of Vaccine Administrator **Date**