



# Immunization Consent

Please fill out the following information for the PERSON BEING VACCINATED:

Last Name	First Name	MI	Date of Birth	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Phone #
Social Security Number (Last 4 Digits Only)		Race <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Other		<input type="checkbox"/> White <input type="checkbox"/> Alaskan	<input type="checkbox"/> Hispanic <input type="checkbox"/> Native American	
Street Address		City/State			Zip Code	
Physician Name			Do you live in the city limits of Columbia, Missouri? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Check One:     Medicaid (Straight)     HC USA     MO CARE     Molina    # \_\_\_\_\_  
 Uninsured (No health insurance)  
 Medicare # \_\_\_\_\_  
 Insured (name of company) \_\_\_\_\_

Does your insurance cover vaccines?     Yes     No     I Don't Know  
If you have insurance, does it:     Cover some vaccines, but not all     Cover vaccines, but limits the coverage to a certain amount

If your insurance covers vaccines, why did you choose to be vaccinated here instead of your Primary Care Provider? *Check all that apply.*  
 I do not have a physician     My physician does not have vaccines  
 I was not able to get an appointment with my physician     The Health Department is more convenient  
 I prefer the Health Department over my physician for vaccines     My insurance has a high deductible and the Health Department is more affordable

Other (please explain): \_\_\_\_\_

I have been given a copy and have read, or had explained to me, the information in the Vaccine Information Statement for the vaccine(s) checked below. I understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) be given to me or to the person named above for whom I am authorized to make this request.

\_\_\_\_\_  
Authorized signature (client, if 18 or older, or Parent/Legal Guardian)

\_\_\_\_\_  
Date

↓FOR CLINIC USE ONLY↓

DTaP (VFC Only)	1 2 3 4 5	HIB (VFC Only)	PENTACEL (VFC Only)	1 2 3 4	IPV	VFC	For Sale	1 2 3 4
Td/Tdap	VFC 317 For Sale 1 2 3	PNEUMOVAX	VFC For Sale	1 2	Twinrix	(For Sale Only) 1 2 3		
PEDIARIX (VFC Only)	KINRIX (VFC Only) 1 2 3	PREVNAR (VFC Only)	1 2 3 4		HEP B	VFC 317 For Sale	1 2 3	
MMR	VFC For Sale 1 2	VARICELLA	VFC For Sale	1 2	HEP A	VFC 317 For Sale	1 2	
MENACTRA	VFC For Sale 1 2	ROTATEQ (VFC Only)	1 2 3		GARDASIL	VFC For Sale	1 2 3	
OTHER	VFC 317 For Sale	Comments <input type="checkbox"/> No imm record <input type="checkbox"/> MOHSAIC down <input type="checkbox"/> # vaccines given per client/parent request			Client counseled to receive future vaccines from <input type="checkbox"/> PCP <input type="checkbox"/> FQHC			
Initials of Vaccine Administrator(s):					Date:			
Initials:					Date:			

## Screening Questionnaire for Immunization

Please complete the following information **about the person being vaccinated**. If a question is not clear, please ask us to explain it. Thank you.

<b>For Adults</b> If <b>you</b> are receiving the vaccine(s), complete this column ↓		YES	NO	<b>For Children/Dependents</b> If <b>your child or other dependent</b> is receiving the vaccine(s), complete this column ↓		YES	NO
1. Are you sick today?	<input type="checkbox"/>	<input type="checkbox"/>		1. Is the child/dependent sick today?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Do you have allergies to medications, food or any vaccine?	<input type="checkbox"/>	<input type="checkbox"/>		2. Does the child/dependent have allergies to medications, food or an vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Have you ever had a serious reaction after receiving a vaccination?	<input type="checkbox"/>	<input type="checkbox"/>		3. Has the child/dependent had a serious reaction to a vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Do you have cancer, leukemia, HIV/AIDS or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>		4. Has the child/dependent had a seizure or brain problem?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Do you take cortisone, prednisone, other steroids, or anti-cancer drugs or have you had x-ray treatments?	<input type="checkbox"/>	<input type="checkbox"/>		5. Does the child/dependent have cancer, leukemia, HIV/AIDS, or any other immune system problems?	<input type="checkbox"/>	<input type="checkbox"/>	
6. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?	<input type="checkbox"/>	<input type="checkbox"/>		6. In the past 3 months, has the child/ dependent taken cortisone, prednisone, other steroids, or anti-cancer drugs, or had x-ray treatments?	<input type="checkbox"/>	<input type="checkbox"/>	
7. For women: are you pregnant or is there a chance you could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>		7. Has the child/dependent received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	
8. Have you received any vaccinations in the past four weeks?	<input type="checkbox"/>	<input type="checkbox"/>		8. Is the child/dependent pregnant or is there a chance she could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	
9. Do you need a tuberculin (TB) skin test in the next 4 to 6 weeks?	<input type="checkbox"/>	<input type="checkbox"/>		9. Has the child/dependent received vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	
10. Have you ever been diagnosed with Guillain Barre' Syndrome (a paralyzing illness)?	<input type="checkbox"/>	<input type="checkbox"/>		10. Does the child/dependent need a tuberculin (TB) skin test in the next 4 to 6weeks?	<input type="checkbox"/>	<input type="checkbox"/>	
11. Do you have close contact with someone who has a suppressed immune system (HIV, cancer, chemo, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>		11. Has the child/dependent ever been diagnosed with Guillain Barre' Syndrome (a paralyzing illness)?	<input type="checkbox"/>	<input type="checkbox"/>	
				12. Was the child/dependent born with gastrointestinal (GI) blockage or had abdominal surgery, a history of GI problems or currently have a GI illness?	<input type="checkbox"/>	<input type="checkbox"/>	
*Revised 8/11/06				13. Does the child/dependent have close contact with someone who has a suppressed immune system (HIV, cancer, chemo, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	

**Form Completed By:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If not the parent and signing for another person, your relationship to that person:

legal guardian     other \_\_\_\_\_

**Reviewed By:** \_\_\_\_\_ **Date:** \_\_\_\_\_