



Public Health  
Prevent. Promote. Protect.

# LAFAYETTE COUNTY HEALTH DEPARTMENT

## ADULT IMMUNIZATION CONSENT

CLIENT INFORMATION

Date: \_\_\_/\_\_\_/\_\_\_ Name - Last: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Sex:  Male  Female

Social Security # \_\_\_\_\_

I would like to receive emails on special events/updates - email address: \_\_\_\_\_

Ethnicity:  Hispanic or Latino  Non Hispanic or Latino Race:  Amer. Indian/Alaskan Native  Asian  
 Black/African  Amer. Native Hawaiian or Other Pacific Islander  White

Patient/Guardian Name (Print) Last: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

I have been given a copy and have read, or had explained to me, the information in the "Vaccine Information Statement(s)," where applicable, for the vaccine(s) indicated below. I have had a chance to ask questions and had them answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) currently due for which I have signed below be given to me or to the person named above for whom I am authorized pursuant to Section 431.058, RSMo to make this request.

Patient / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

INSURANCE INFO

Please check all that apply:  My insurance doesn't pay for vaccines  American Indian  No Insurance  
 Medicaid Eligible—Medicaid # \_\_\_\_\_  Insured—Fill out Policy Holder information below

Primary insur. ID# \_\_\_\_\_ Group # \_\_\_\_\_ Patient's relationship to insured  self  spouse  dependent

Insured First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Secondary Insur. Name: \_\_\_\_\_ Secondary member ID# \_\_\_\_\_ Secondary Group ID# \_\_\_\_\_

### FOR CLINIC USE ONLY

Lafayette County Health Department  
547 South Business Hwy. 13,  
Lexington, MO 64067 (660) 259-4371

317

Purchased

VACCINE NAME	DOSE NUMBER GIVEN TODAY	VACCINE NAME	DOSE NUMBER GIVEN TODAY	VACCINE NAME	DOSE NUMBER GIVEN TODAY
VACCINE MANUFACTURER / LOT NUMBER / EXPIRATION DATE		VACCINE MANUFACTURER / LOT NUMBER / EXPIRATION DATE		VACCINE MANUFACTURER / LOT NUMBER / EXPIRATION DATE	
INJECTION SITE AND ROUTE		INJECTION SITE AND ROUTE		INJECTION SITE AND ROUTE	
VIS REVISION DATE	DATE VIS GIVEN	VIS REVISION DATE	DATE VIS GIVEN	VIS REVISION DATE	DATE VIS GIVEN
VACCINE NAME	DOSE NUMBER GIVEN TODAY	VACCINE NAME	DOSE NUMBER GIVEN TODAY	VACCINE NAME	DOSE NUMBER GIVEN TODAY
VACCINE MANUFACTURER / LOT NUMBER / EXPIRATION DATE		VACCINE MANUFACTURER / LOT NUMBER / EXPIRATION DATE		VACCINE MANUFACTURER / LOT NUMBER / EXPIRATION DATE	
INJECTION SITE AND ROUTE		INJECTION SITE AND ROUTE		INJECTION SITE AND ROUTE	
VIS REVISION DATE	DATE VIS GIVEN	VIS REVISION DATE	DATE VIS GIVEN	VIS REVISION DATE	DATE VIS GIVEN

VACCINE NAME DOSE NUMBER GIVEN TODAY

VACCINE MANUFACTURER / LOT NUMBER / EXPIRATION DATE

INJECTION SITE AND ROUTE

VIS REVISION DATE DATE VIS GIVEN

SIGNATURE & Title of Vaccine Administrator

X \_\_\_\_\_

- Immunization status reviewed.
- No true contraindications to vaccinations per Immunization questionnaire/interview
- Potential side effects reviewed. Encouraged to contact LCHD with questions and concerns.
- Vaccination information statements given to parents
- Discussed dosage & use of Tylenol to manage side effects.
- Vaccines recorded on vaccination card.
- Return \_\_\_\_\_

PER PROTOCOL ORDER SIGNED \_\_\_\_\_ DATE: \_\_\_\_\_

Client refused vaccine: \_\_\_\_\_

# ADULT IMMUNIZATION QUESTIONNAIRE

Circle correct response

<b>1.</b>	<b>Does the person receiving the vaccine:</b>		
a)	currently have an illness more serious than a cold (fever, ear infection, diarrhea, vomiting)?	YES	NO
b)	have contact with someone who is HIV positive?	YES	NO
c)	have contact with someone who is receiving treatment for cancer or who has deficiency of the immune system?	YES	NO
d)	have a personal or family history of convulsions, seizures, tuberculosis or Guillan-Barre Syndrome	YES	NO
e)	have contact with someone who has not had any vaccinations?	YES	NO
<b>2.</b>	<b>Has the person receiving the vaccine:</b>		
a)	had a reaction to a vaccine other than redness, soreness and swelling in the injection site?	YES	NO
b)	taken a drug that affects the immune system (such as immune globulin or steroids) in the last 3-6 months?	YES	NO
c)	had an allergic reaction to:		
	a medication (name of medication _____)	YES	NO
	thimerosal (a preservative)	YES	NO
	latex	YES	NO
	Eggs/chicken	YES	NO
	gelatin	YES	NO
	Flu shot	YES	NO
d)	had a high fever or other serious reaction to a previous dose of vaccine?	YES	NO
e)	tested positive for HIV?	YES	NO
f)	ever had Chicken Pox (Varicella)? Actual disease or Vaccine	YES	NO
<b>3.</b>	<b>Is the person receiving the vaccine pregnant?</b>	YES	NO
<b>4.</b>	<b>Has the person being immunized received any vaccines in the last month?</b>	YES	NO

\_\_\_\_\_  
Signature of Client, Parent or Guardian

\_\_\_\_\_  
Relationship or Client

If you **DO NOT** want your immunization record to be entered into the Missouri Department of Health and Senior Services Immunization Registry (Show-Me-Vax) computer system, please mark No. \_\_\_\_\_NO

*I acknowledge I have been informed of the location of the Notice of Privacy Practices and have been provided an opportunity to review it.*

\_\_\_\_\_  
Signature of Client, Parent or Guardian

\_\_\_\_\_  
Today's Date

# LAFAYETTE COUNTY HEALTH DEPARTMENT

INFORMATION DATA SHEET (REVISED 9-2015)

WIC:  Yes  No

Mother's Name: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_ / \_\_\_ / \_\_\_\_\_

Father's Name: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_ / \_\_\_ / \_\_\_\_\_

**AND/OR**

Legal Guardian Name \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_ / \_\_\_ / \_\_\_\_\_

**INSURANCE:**  Medicaid  Medicare  None  Private  Underinsured

Child's Primary physician: \_\_\_\_\_

**If on insurance, please check below which insurance plan you have and enter policy # here:** \_\_\_\_\_

<input type="checkbox"/> Aetna	<input type="checkbox"/> Cigna	<input type="checkbox"/> Home State	<input type="checkbox"/> Medicare D	<input type="checkbox"/> Tricare
<input type="checkbox"/> Blue Cross/ Blue Shield	<input type="checkbox"/> Coventry	<input type="checkbox"/> Humana	<input type="checkbox"/> Meritain	<input type="checkbox"/> United Health Care
<input type="checkbox"/> ChampVA	<input type="checkbox"/> Aetna Better Health	<input type="checkbox"/> Medicare Part B	<input type="checkbox"/> MOCare	<input type="checkbox"/> UMR

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## Patient Record of Disclosures/Privacy Practices Acknowledgement

In general, the HIPPA privacy rule gives the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

**I wish to be contacted in the following manner:  
(Check all that apply)**

**HOME TELEPHONE**

- OK to leave a message w/detailed information
- OK to leave a message w/call back number only

**WORK TELEPHONE**

- OK to leave a message w/detailed information
- OK to leave a message w/call back number only

**CELL PHONE**

- OK to leave a message w/detailed information
- OK to leave a message w/call back number only

**WRITTEN COMMUNICATION**

- OK to mail to my home address
- OK to mail to my work/office address \_\_\_\_\_
- OK to fax to this number \_\_\_\_\_

\_\_\_\_\_  
**Client/Parent or Legal Guardian Signature**

## OFFICE USE ONLY

**Method of Communications:**

**Record of Disclosures of Protected Health Information**

Date	Mail postcard	Other		Date	Disclosed to Whom - Address or Fax #	Description of Disclosure/ Purpose of Disclosure	Staff