LAFAYETTE COUNTY HEALTH DEPARTMENT

CHILDREN IMMUNIZATION CONSENT

Public Health
Prevent. Promote. Protect.

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

Parent/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

☐ **Not** VFC Eligible
☐ 317 ☐ Purchased

VFC Eligible
☐ Medicaid ☐ Amer Indian Or Alaska Native
☐ Uninsured ☐ Underinsured (FQHC/RHC only)

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:_____

8-2015 J/Immuniz/Imm. Pkt. forms

CHILDREN IMMUNIZATION QUESTIONNAIRE

		Circle correct response	
1.	**Does the person receiving the vaccine:**		
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
2.	**Has the person receiving the vaccine:**		
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)	cried inconsolably for 3 or more hours within two days after receiving a vaccination?	YES	NO
g)	ever had Chicken Pox (Varicella)? Actual disease approximate month_____ year _____	YES	NO
3.	**Is the person receiving the vaccine pregnant?**	YES	NO
4.	**Has the person being immunized received any vaccines in the last month?**	YES	NO

FOR PATIENTS RECEIVING A FLUMIST (NASAL) VACCINATION ONLY – Please answer the following questions

1.	Is the person to be vaccinated younger than age 2 years or older than age 49 years?	YES	NO
2.	Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g. diabetes), or anemia or another blood disorder?	YES	NO
3.	Does the person to be vaccinated have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs?	YES	NO
4.	Is the person to be vaccinated receiving antiviral medications?	YES	NO
5.	Is the person to be vaccinated receiving aspirin therapy or aspirin-containing therapy?	YES	NO
6.	Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit?	YES	NO
7.	In the past 12 months, has a health-care provider ever told the person being vaccinated that they had wheezing or asthma?	YES	NO

_____ _____

Signature of Client, Parent or Guardian **Relationship or Client**

If you **DO NOT** want your child's 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: _____

___Aetna	___Cigna	___Home State	___Medicare D	___TriCare
___Blue Cross/ Blue Shield	___Coventry	___ Humana	___Meritain	___United Health Care
___ChampVA	___Aetna Better Health	___Medicare Part B	___ MOCare	___ 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