STATE OF MISSOURI
DEPARTMENT OF HEALTH AND SENIOR SERVICES

IMMUNIZATION CONSENT AND HISTORY

CLINIC IDENTIFICATION

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SEX
				☐ Male ☐ Female

STREET ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NO.

RACE (SELECT ALL THAT APPLY)

☐ Amer Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ Black or African American ☐ White

ETHNICITY

☐ Hispanic or Latino ☐ Not Hispanic or Latino

PARENT/GUARDIAN FULL NAME

I have been given 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.

VACCINE AND ROUTE (CIRCLE TYPE GIVEN WHERE APPLICABLE)	VISIT NO. & M/D/Y GIVEN	INJECTION SITE	VACCINE MANUFACTURER/ LOT NUMBER	VACCINE EXP. DATE	VIS REVISION DATE	DATE VIS GIVEN	SIGNATURE OF VACCINATOR
Hepatitis B							
Hep B IM							
Diphtheria, Tetanus, Pertussis							
DTap DTP DT IM							
Haemophilus influenzae type b							
Hib IM							
Polio							
Polio SQ IM							
Pneumococcal							
PCV 13 IM							

PATIENT OR PARENT/GUARDIAN CONSENT

VISIT #1 DATE

SIGNATURE

ELIGIBILITY STATUS
☐ Medicaid
☐ No health insurance
☐ Amer Indian/Alaska Native
☐ Underinsured (FQHC/RHC)
☐ **NOT VFC Eligible**

VISIT #2 DATE

SIGNATURE

ELIGIBILITY STATUS
☐ Medicaid
☐ No health insurance
☐ Amer Indian/Alaska Native
☐ Underinsured (FQHC/RHC)
☐ **NOT VFC Eligible**

VISIT #3 DATE

SIGNATURE

ELIGIBILITY STATUS
☐ Medicaid
☐ No health insurance
☐ Amer Indian/Alaska Native
☐ Underinsured (FQHC/RHC)
☐ **NOT VFC Eligible**

VISIT #4 DATE

SIGNATURE

ELIGIBILITY STATUS
☐ Medicaid
☐ No health insurance
☐ Amer Indian/Alaska Native
☐ Underinsured (FQHC/RHC)
☐ **NOT VFC Eligible**

COMMENTS

PATIENT NAME

IMMUNIZATION CONSENT AND HISTORY (CONTINUED)

VACCINE AND ROUTE (CIRCLE TYPE GIVEN WHERE APPLICABLE)	VISIT NO. & M/D/Y GIVEN	INJECTION SITE	VACCINE MANUFACTURER/ LOT NUMBER	VACCINE EXP. DATE	VIS REVISION DATE	DATE VIS GIVEN	SIGNATURE OF VACCINATOR	PATIENT OR PARENT/GUARDIAN CONSENT
Pneumococcal polysaccharide PPSV 23 SQ IM								**VISIT #5** DATE SIGNATURE
Measles, Mumps, Rubella MMR SQ								**ELIGIBILITY STATUS** ☐ Medicaid ☐ No health insurance ☐ Amer Indian/Alaska Native ☐ Underinsured (FQHC/RHC) ☐ **NOT VFC Eligible**
Varicella Varicella SQ								
Rotavirus RV1 Oral RV5 Oral								**VISIT #6** DATE SIGNATURE
Hepatitus A Hep A IM								**ELIGIBILITY STATUS** ☐ Medicaid ☐ No health insurance ☐ Amer Indian/Alaska Native ☐ Underinsured (FQHC/RHC) ☐ **NOT VFC Eligible**
Human papilloma-virus HPV IM								**VISIT #7** DATE SIGNATURE
Meningococcal MenACWY IM								**ELIGIBILITY STATUS** ☐ Medicaid ☐ No health insurance ☐ Amer Indian/Alaska Native ☐ Underinsured (FQHC/RHC) ☐ **NOT VFC Eligible**
Meningococcal B MenB IM								**VISIT #8** DATE SIGNATURE
Tetanus, Diphtheria, Pertussis (7 years old and above) Tdap IM Td IM								**ELIGIBILITY STATUS** ☐ Medicaid ☐ No health insurance ☐ Amer Indian/Alaska Native ☐ Underinsured (FQHC/RHC) ☐ **NOT VFC Eligible**
Influenza IIV (inactive) IM RIV (recombinant) IM LAIV (live attenuated intranasal) IN								**VISIT #9** DATE SIGNATURE
Zoster (Shingles) RVZ (recombinant) IM ZVL (live) SQ								**ELIGIBILITY STATUS** ☐ Medicaid ☐ No health insurance ☐ Amer Indian/Alaska Native ☐ Underinsured (FQHC/RHC) ☐ **NOT VFC Eligible**
								VISIT #10 DATE SIGNATURE
Other								**ELIGIBILITY STATUS** ☐ Medicaid ☐ No health insurance ☐ Amer Indian/Alaska Native ☐ Underinsured (FQHC/RHC) ☐ **NOT VFC Eligible**
Other								

COMMENTS