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	PHONE

RACE (select all that apply)
❑ Amer Indian or Alaska Native
❑ Asian
❑ Black or African American
❑ Native Hawaiian or Other Pacific Islander
❑ White

ETHNICITY
❑ Hispanic or Latino
❑ Non Hispanic or Latino

PARENT/GUARDIAN FULL NAME

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.

Vaccine and Route (circle type given where pplicable)	Visit # and 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
Hepatitis B Hep B IM								**Visit # 1** Date Signature: **Eligibility Status**: ❑ Medicaid ❑ No health insurance ❑ Amer Indian/Alaska Native ❑ Underinsured (FQHC/RHC) ❑ **NOT VFC Eligible**
Diphtheria, Tetanus, Pertussis DTaP DTP DT IM								**Visit # 2** Date Signature: **Eligibility Status**: ❑ Medicaid ❑ No health insurance ❑ Amer Indian/Alaska Native ❑ Underinsured (FQHC/RHC) ❑ **NOT VFC Eligible**
Haemophilus influenzae type b Hib IM								**Visit # 3** Date Signature: **Eligibility Status**: ❑ Medicaid ❑ No health insurance ❑ Amer Indian/Alaska Native ❑ Underinsured (FQHC/RHC) ❑ **NOT VFC Eligible**
Polio Polio SQ IM								**Visit # 4** Date Signature: **Eligibility Status**: ❑ Medicaid ❑ No health insurance ❑ Amer Indian/Alaska Native ❑ Underinsured (FQHC/RHC) ❑ **NOT VFC Eligible**
Pneumococcal conjugate PCV 7 IM PCV 13 IM								

Comments

IMMUNIZATION CONSENT AND HISTORY *(continued)*

PATIENT NAME

Vaccine and Route (circle type given where applicable)	Visit # and 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: **Eligibility Status**: ❑ Medicaid ❑ No health insurance ❑ Amer Indian/Alaska Native ❑ Underinsured (FQHC/RHC) ❑ **NOT VFC Eligible**
Measles, Mumps, Rubella MMR SQ								
Varicella Varicella SQ								
Rotavirus RV1 Oral RV5 Oral								**Visit # 6** Date Signature: **Eligibility Status**: ❑ Medicaid ❑ No health insurance ❑ Amer Indian/Alaska Native ❑ Underinsured (FQHC/RHC) ❑ **NOT VFC Eligible**
Hepatitis A Hep A IM								
Human papilloma-virus HPV2 IM HPV4 IM								**Visit # 7** Date Signature: **Eligibility Status**: ❑ Medicaid ❑ No health insurance ❑ Amer Indian/Alaska Native ❑ Underinsured (FQHC/RHC) ❑ **NOT VFC Eligible**
Meningococcal MCV4 IM MPSV4 SC								**Visit # 8** Date Signature: **Eligibility Status**: ❑ Medicaid ❑ No health insurance ❑ Amer Indian/Alaska Native ❑ Underinsured (FQHC/RHC) ❑ **NOT VFC Eligible**
Tetanus, Diphtheria, Pertussis **(7years old and above)** Tdap IM Td IM								
Influenza TIV (inactivated) IM LAIV (live attenuated) Intranasal IN								**Visit # 9** Date Signature: **Eligibility Status**: ❑ Medicaid ❑ No health insurance ❑ Amer Indian/Alaska Native ❑ Underinsured (FQHC/RHC) ❑ **NOT VFC Eligible**
Other								**Visit # 10** Date Signature: **Eligibility Status**: ❑ Medicaid ❑ No health insurance ❑ Amer Indian/Alaska Native ❑ Underinsured (FQHC/RHC) ❑ **NOT VFC Eligible**
Other								
Other								
Other								

Comments