



IMMUNIZATION CONSENT AND HISTORY

CLINIC IDENTIFICATION

LAST NAME		FIRST NAME		MI	SOCIAL SECURITY #	ID #	DATE OF BIRTH
STREET ADDRESS			CITY	STATE	ZIP CODE	PHONE #	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
RACE (select all that apply) <input type="checkbox"/> Amer Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American				ETHNICITY <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non Hispanic or Latino		PARENT/GUARDIAN FULL NAME	
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White							

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 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
Hepatitis B-1 IM								<b>Visit # 1</b> Date Signature  <input type="checkbox"/> Not VFC Eligible <b>VFC Eligibility</b> <input type="checkbox"/> Medicaid <input type="checkbox"/> Uninsured <input type="checkbox"/> Amer Indian or Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC)
Hepatitis B-2 IM								
Hepatitis B-3 IM								
Hepatitis B-4 IM								
DTaP DTP DT-1 IM								

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DTaP DTP DT-2 IM								<b>Visit # 2</b> Date Signature  <input type="checkbox"/> Not VFC Eligible <b>VFC Eligibility</b> <input type="checkbox"/> Medicaid <input type="checkbox"/> Uninsured <input type="checkbox"/> Amer Indian or Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC)
DTaP DTP DT-3 IM								
DTaP DTP DT-4 IM								
DTaP DTP DT-5 IM								
DTaP DTP DT-6 IM								
Hib-1 IM							<b>Visit # 3</b> Date Signature  <input type="checkbox"/> Not VFC Eligible <b>VFC Eligibility</b> <input type="checkbox"/> Medicaid <input type="checkbox"/> Uninsured <input type="checkbox"/> Amer Indian or Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC)	
Hib-2 IM								
Hib-3 IM								
Hib-4 IM								
Polio-1 SQ IM							<b>Visit # 4</b> Date Signature  <input type="checkbox"/> Not VFC Eligible <b>VFC Eligibility</b> <input type="checkbox"/> Medicaid <input type="checkbox"/> Uninsured <input type="checkbox"/> Amer Indian or Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC)	
Polio-2 SQ IM								
Polio-3 SQ IM								
Polio-4 SQ IM								
MMR-1 SQ								
MMR-2 SQ								

Comments

PATIENT NAME

**IMMUNIZATION CONSENT AND HISTORY (continued)**

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
Hepatitis A-1	IM							<b>Visit # 5</b> Date Signature  <input type="checkbox"/> Not VFC Eligible <b>VFC Eligibility</b> <input type="checkbox"/> Medicaid <input type="checkbox"/> Uninsured <input type="checkbox"/> Amer Indian or Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC)
Hepatitis A-2	IM							
Hepatitis A-3	IM							
PCV 7-1	IM							<b>Visit # 6</b> Date Signature  <input type="checkbox"/> Not VFC Eligible <b>VFC Eligibility</b> <input type="checkbox"/> Medicaid <input type="checkbox"/> Uninsured <input type="checkbox"/> Amer Indian or Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC)
PCV 7-2	IM							
PCV 7-3	IM							
PCV 7-4	IM							<input type="checkbox"/> Not VFC Eligible <b>VFC Eligibility</b> <input type="checkbox"/> Medicaid <input type="checkbox"/> Uninsured <input type="checkbox"/> Amer Indian or Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC)
Varicella-1	SQ							
Varicella-2	SQ							
Rotavirus-1	Oral							<b>Visit # 7</b> Date Signature  <input type="checkbox"/> Not VFC Eligible <b>VFC Eligibility</b> <input type="checkbox"/> Medicaid <input type="checkbox"/> Uninsured <input type="checkbox"/> Amer Indian or Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC)
Rotavirus-2	Oral							
Rotavirus-3	Oral							
Tdap	IM							<input type="checkbox"/> Not VFC Eligible <b>VFC Eligibility</b> <input type="checkbox"/> Medicaid <input type="checkbox"/> Uninsured <input type="checkbox"/> Amer Indian or Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC)
Td	IM							
Td	IM							

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Td	IM							<b>Visit # 8</b> Date Signature  <input type="checkbox"/> Not VFC Eligible <b>VFC Eligibility</b> <input type="checkbox"/> Medicaid <input type="checkbox"/> Uninsured <input type="checkbox"/> Amer Indian or Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC)
Td	IM							
MCV4	IM							
Influenza	IM							<b>Visit # 9</b> Date Signature  <input type="checkbox"/> Not VFC Eligible <b>VFC Eligibility</b> <input type="checkbox"/> Medicaid <input type="checkbox"/> Uninsured <input type="checkbox"/> Amer Indian or Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC)
Influenza	IM							
Influenza	IM							
Influenza	IM							<input type="checkbox"/> Not VFC Eligible <b>VFC Eligibility</b> <input type="checkbox"/> Medicaid <input type="checkbox"/> Uninsured <input type="checkbox"/> Amer Indian or Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC)
PPV 23	SQ IM							
HPV	IM							
HPV	IM							<b>Visit # 10</b> Date Signature  <input type="checkbox"/> Not VFC Eligible <b>VFC Eligibility</b> <input type="checkbox"/> Medicaid <input type="checkbox"/> Uninsured <input type="checkbox"/> Amer Indian or Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC)
HPV	IM							
Other								
Other								<input type="checkbox"/> Not VFC Eligible <b>VFC Eligibility</b> <input type="checkbox"/> Medicaid <input type="checkbox"/> Uninsured <input type="checkbox"/> Amer Indian or Alaska Native <input type="checkbox"/> Underinsured (FQHC/RHC)
Other								
Other								
Comments								