IMMUNIZATION CONSENT FORM

If you would like your child to receive immunizations on the Medical Mobile Unit, please complete this form. All vaccines are provided at no out of pocket expense for your child/family. If you do have insurance, Jordan Valley Community Health Center will send a bill to your insurance company. You are not responsible for any charges not covered by your insurance company.

1) **According to your school's healthcare provider(s),** your child is due / overdue for the following immunizations.
(School personnel will circle all that apply)

Hep B Tdap/Dtap Polio MMR Varicella Menactra Gardasil Flu/Flumist Hep A Prevnar

2) **Please check which applies to your child:**

_____does not have insurance _____insurance plan does not cover these vaccinations
_____enrolled in Medicaid _____is an Alaskan native or Native American
_____Insurance plan covers immunizations, but I would like for my child to receive the immunizations on the JVCHC Mobile Unit.

3) Child & Guardian Information:

Child's Name:	SS#::	DOB:	Gender & Race:
Street Address:	City:	Zip:	Phone:
Medicaid #:			

Guardian's Name:	SS#:	DOB:	Gender:
Street Address:	City:	Zip:	Phone:
Insurance Co. Name:		Policy #:	

4**) Please initial the vaccinations, required by the State of Missouri, you would like your child to receive:**

_____ Hepatitis B _____ Tdap/Dtap _____ Polio _____ Varicella _____ MMR

5) The Mobile Unit offers the following immunizations that are not required for school participation, but are recommended by the CDC.
Please initial the vaccinations you would like your child to receive:

_____ Menactra _____ Gardasil _____ Flu _____ Hep A _____ Prevnar

6) Please note, the federal government requires us to ask you for this information and it will be used for government reporting purposes only. Neither your name nor any other identifying information will ever be disclosed and we will not use this information for any other purpose. **Please circle your family size and the range of your annual income.**

Family Size	A	B	C	D
1	$0 - $ 11,170	$ 11,171 - $ 16,755	$ 16,756 - $ 22,340	$ 22,341 or greater
2	$0 - $ 15,130	$ 15,131 - $ 22,695	$ 22,696 - $ 30,260	$ 30,261 or greater
3	$0 - $ 19,090	$ 19,091 - $ 28,635	$ 28,636 - $ 38,180	$ 38,181 or greater
4	$0 - $ 23,050	$ 23,051 - $ 34,575	$ 34,576 - $ 46,100	$ 46,101 or greater
5	$0 - $ 27,010	$ 27,011 - $ 40,515	$ 40,516 - $ 54,020	$ 54,021 or greater
6	$0 - $ 30,970	$ 30,971 - $ 46,455	$ 46,456 - $ 61,940	$ 61,941 or greater
7	$0 - $ 34,930	$ 34,931 - $ 52,395	$ 52,396 - $ 69,860	$ 69,861 or greater
8	$0 - $ 38,890	$ 38,891 - $ 58,335	$ 58,336 - $ 77,780	$ 77,781 or greater
9	$0 - $ 42,850	$ 42,851 - $ 64,275	$ 64,276 - $ 85,700	$ 85,701 or greater
10	$0 - $ 46,810	$ 46,811 - $ 70,215	$ 70,216 - $ 93,620	$ 93,621 or greater

PLEASE COMPLETE INFORMATION ON PAGE 2

7) PLEASE CIRCLE 'YES' OR 'NO'

Yes/No This child is allergic to medicines, foods, eggs, or vaccinations.
Yes/No This child has had a serious reaction to a vaccine in the past.
Yes/No This child or one of his/her immediate family member has seizures, brain-nerve problem, bleeding disorder or on aspirin or blood thinners.
Yes/No This child has chronic lung, heart or kidney disease, diabetes, asthma or other chronic illness.
Yes/No This child has cancer, leukemia, AIDS or other immune system problem:
Yes/No This child has taken cortisone, prednisone, other steroids or anticancer drugs or had X-ray treatments in the last six months.
Yes/No This child had a transfusion of blood or blood products or has been given immune (gamma) globulin in the last 6 weeks.
Yes/No This child/teen could be pregnant or has a chance she could become pregnant in the next month.
Yes/No This child has received vaccinations in the last four weeks.

8) READ AND SIGN BELOW:

I have been given a copy of and have read or had explained to me, the information in the "Vaccine Information Statement(s)" for the disease(s) and vaccine(s) to be administered to this child. I have had a chance to ask questions that were 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.

Parent/Guardian signature:_____Date:_____

JVCHC to complete:

Child's Name:	DOB:	Temp:	Ht:	Wt:
Practitioner:		Nurse:		
School:		Date:		

Vaccine	Brand Name/MFGS	Lot#/EXP	Site	Adm. Initials	Dose #	Next Dose Due
Tdap (11-18yo)	Adacel/S-P/GSK					
Dtap/IPV (4-6 yo)	Kinrix/GSK					
Dtap/IPV/Hep B	Pediarix					
Dtap/IPV/HIB	Pentacel					
Dtap	Infanrix/GSK					
MCV4	Menactra					
HPV	Gardasil/Merck					
MMR						
Varicella	Varivax/Merck					
IPV	Polio/S-P					
Hep A	Havrix/GSK					
PCV 13	Prevnar/Wyeth					
Hep B	Engerix/Merck					
HIB	Pedvax/S-P					
HIB	ActHib (4 doses)					
Rotovirus	Rotateq/Merck					
FluMist	MedIM					
FluZone	S-P					

PLEASE COMPLETE INFORMATION ON PAGE 2