COMMUNITY HEALTH CENTER OF CENTRAL MISSOURI
CHILD/ADOLESCENT IMMUNIZATION CONSENT AND SCREENING

1511 Christy Drive Jefferson City, MO 65109 ***All areas in bold must be completed before being seen**.*

Name: (last) (first) (MI)					**Date of Birth**:
Address:					**Gender** (circle one) Male Female
City:	**State**:	**Zip Code:**	**Provider:**	**Phone #** ( )	Alternate Phone # ( )

RACE: (circle one) White Black/African American Asian/Pacific Islander Other	**Program eligibility**: ***Please Mark One*** ☐ Medicaid #_____ ☐ No Insurance ☐ Insurance does not cover needed vaccines ☐ Insurance – can not afford deductible ☐ Alaskan Native/American Indian ☐ None of the above

Screening for Child & Teen Immunization

1.	Is the child sick today	Yes	No	Don't Know
2.	Does the child have allergies to medication, food, or any vaccine? List_____	Yes	No	Don't Know
3.	Has the child ever had a serious reaction after receiving a vaccination?	Yes	No	Don't Know
4.	Has the child had a seizure, brain problem or Guillen-Barre Syndrome?	Yes	No	Don't Know
5.	Does the child have cancer, leukemia, AIDs or any other immune system disorder?	Yes	No	Don't Know
6.	Has the child taken cortisone, prednisone, other steroids, or anti-cancer drugs or had x-ray treatments in the past 3 months?	Yes	No	Don't Know
7.	Has the child received a blood transfusion or taken a medicine called Immune (gamma) globulin in the past year?	Yes	No	Don't Know
8.	Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	Yes	No	N/A
9.	Has the child received vaccinations in the past 4 weeks?	Yes	No	Don't Know
10.	Has your child ever had Chickenpox?	Yes	No	Don't Know

I have been given a copy and have read, or had explained to me, the information in the "Vaccine Information Statement(s)" for the vaccine(s) myself or the person named above will be receiving today. 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 the person named above for whom I am authorized pursuant to Section 431.058 RMSo to make this request.
I acknowledge that I have had the opportunity to review the Community Health Center of Central Missouri's Privacy Practice Notice and have been given a copy.

Signature: _____ **Circle:** Self/Parent/Guardian/Designee

Print Signers Name: _____ **Date:** _____

**Please wait 15 minutes after you receive your immunizations. Rarely a severe reaction to an immunization occurs. Everyone is screened before receiving any immunization for this reason. If a severe reaction is going to occur it usually occurs within 15 minutes of receiving the immunization. For this reason we ask you to wait 15 minutes after you receive an immunization before leaving the building. If you have no problems after this time you may leave.*