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

CHRISTIAN COUNTY
HEALTH DEPARTMENT

Christian County Health Department
Screening Questionnaire for Adult Immunizations

Client Name: _____ Date of Birth: _____

1.) Yes___ No___ Are you sick today?

2.) Yes___ No___ Do you have allergies to medications, food, or any vaccine?
If yes, please specify: _____

3.) Yes___ No___ Have you ever had a serious reaction after receiving vaccine?

4.) Yes___ No___ Do you, any person who lives with you, or who you take care of have cancer, Leukemia, AIDS, or any other immune system problem?

5.) Yes___ No___ Do you, any person who lives with you or who you take care of take cortisone, prednisone, other steroids, anticancer drugs, antivirals, or x-ray treatment?

6.) Yes___ No___ During the past year, have you received a transfusion of blood or plasma, stem cell transplantation, or been given a medicine called immune (gamma) globulin?

7.) Yes___ No___ For Women: Are you pregnant or is there a chance you could become pregnant in the next 3 months?

8.) Yes___ No___ Did you bring your immunization record with you today?

9.) Yes___ No___ Are you covered by Health Insurance? If yes, does your plan specifically state that it covers the immunizations you are here for today? Yes___ No___

Form completed by: _____ Date: _____

CONSENT TO BILL

Client Name: _____

(Please print Client's First Name, Middle Initial, Last Name)

Date of Birth: _____ _____ _____

Month *Day* *Year*

I give permission to the Christian County Health Department to share information about the above-named client as required in regard to billing with Medicaid, Medicare, Private Pay Insurance, and/or the Department of Health & Senior Services when appropriate to provide the above-named client treatment and health related services.

I understand that the confidentiality of the information will be maintained as required by applicable state and federal laws. Information referring to the Christian County Health Department privacy and confidentiality polices have been made available upon request. I further understand information will not be given to care providers that have not signed an agreement with the Christian County Health Department or be used for any other purpose except for billing purposes.

This consent remains in effect unless I give written notice to revoke. I understand my refusal to give permission could influence the ability of the Christian County Health Department to receive payment for services rendered and thus may result in self-payment method.

_____

Print Client/Parent/Guardian First Name, Middle Initial, and Last Name

_____

Client/Parent/Guardian Signature Date

_____

Witness Signature Date

Charge Sheet

CHRISTIAN COUNTY
HEALTH DEPARTMENT

Show them healthy.

301 E BRICK
PO BOX 340
OZARK, MO 65721

Date: _____

Client Name: _____ Phone Number: _____

Address: _____ City: _____ Zip: _____

Insurance Name: _____ Subscriber ID: _____

Thank you for choosing Christian County Health Department to take care of your healthcare needs. Below is a summary of the expected charges for services you will be receiving today.

Today's Charges: Office Visit Fee: $25.00

Vaccines Received: _____

Vaccine Fee for _____ Components @ $8.07 Total Cost: _____

Vaccine Fee for _____ Containing 5 or more comp. @ $32.26 Total Cost: _____

TB Skin Test:	$9 Vaccine Fee-$25 Office Visit Fee	Total TB Test:	$34.00	_____
TB Assessment:	$4 Assessment-$25 Office Visit Fee	Total Assessment:	$29.00	_____
Pregnancy Test:		Total PG Test:	$20.00	_____
Lead Test:		Total Lead Test:	$20.00	_____
*Out of County:		Total Fee:	$20.00	_____

Grand Total: _____

Signature of Client (or Guardian): _____

$20.00 out of county fee will be added for Non-Residents of Christian County

CCHD Staff Only Below This Line

Amount Paid: _____ _____ (CCHD Staff Initial)

Client Signature: _____

Hardship Approved: _____ (CCHD Staff Initial)