SCHOOL_____ JORDAN VALLEY COMMUNITY HEALTH CENTER **GRADE**_____

MEDICAL MOBILE UNIT IMMUNIZATION CONSENT FORM

If you would like your child to receive immunizations on the Medical Mobile Unit, please complete this form. If you **DO NOT** want your child to receive immunizations on the Medical Mobile Unit, please discard this form. All vaccines are provided with 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) Please check what 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

2) Does the child have a primary medical provider (Doctor/Pediatrician/NP) that they go to for wellness checks and when they are sick? Yes___No If yes, please name location/provider_____
Has your child had a wellness visit since their last birthday? ____YES ____NO

3) Child & Guardian Information:

Child's Name:	SS#:	DOB:	Gender: M F	Race:	Language:
Street Address:	City:	Zip:	Phone:		
Medicaid #:	House Apartment Duplex Shelter				
Private Insurance Co. Name:	Policy #:				

Guardian's Name:	DOB:		Gender:
Street Address:	City:	Zip:	Phone:

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

_____**Hepatitis B** _____**Tdap/Dtap** _____**Polio** _____**Varicella** _____**MMR** _____**HIB** _____**Meningococcal**

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:
_____**HPV** _____**Flu** _____**Hepatitis A** _____**Prevnar**

Enclosed is a copy of Vaccine Information Sheets for each of the vaccines. If you have questions about the vaccines that cannot be answered by the Vaccine Information Sheets provided, please talk to your school nurse.

6) PLEASE CIRCLE 'YES' OR 'NO'

Yes/No This child is allergic to medicines, foods, eggs, or vaccinations. **If so, what?** _____
Yes/No This child has had a serious reaction to a vaccine in the past**. If so, what?**_____
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.

Vaccine administrator review date _____***/Initials of reviewer*** _____

7) 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:_____**Email**_____**Date:**_____

(Revised 05/10/2023)

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Vaccine	Brand Name/MFGS	Lot #	EXP	Site	Route	Nurse Administering Vaccine Signature & Credentials	Dose #	Next Dose Due
Tdap (11-18yo)	Adacel/SP Boostrix/GSK				IM			
Dtap/IPV(4-6 yo)	Kinrix/GSK				IM			
Dtap/IPV/Hep B	Pediarix/GSK				IM			
Dtap/IPV/HIB	Pentacel/SP				IM			
Dtap	Daptacel/SP Infanrix/GSK				IM			
MCV4	Menactra/SP				IM			
HPV	Gardasil/Merck				IM			
MMR	MMR/Merck				SQ			
Varicella	Varivax/Merck				SQ			
MMRV	ProQuad/Merck				SQ			
IPV	Polio/SP				IM			
Hep A	Havrix/GSK Vaqta/Merck				IM			
PCV 13	Prevnar/Pfizer				IM			
Hep B	Engerix/GSK Recombivax/Merck				IM			
HIB	Pedvax/Merck ActHIB/SP				IM			
Rotovirus	RotaTeq/Merck				Oral			
Inactivated Flu	Fluvirin/Novartis Fluzone/SP Fluarix/GSK				IM			
Nurse Administering Vaccine (Please Print Name):								
School Site:						**Date Given:**		