TEEN

Livingston County Health Center
800 Adam Drive Chillicothe, MO 64601

Last Name	First Name	MI	Male/Female	Date of Birth

Street Address	City	State	Zip Code	Phone	Age

Form Completed By/Relationship to Child (Please Print)

Insurance Information

_____ **MoHealth/Medicaid** _____ **Private Insurance** _____ **No Insurance**

Race

☐ White
☐ Black
☐ Alaskan/Native American
☐ Asian
☐ Hawaiian/Pacific Islander
☐ Hispanic/Latino
☐ Bi Racial or Multi Racial

Ethnicity

☐ Non-Hispanic
☐ Cuban
☐ Mexican
☐ Central/South American
☐ Puerto Rican
☐ Other

Vaccine Information Statements

☐ Dtap/DT 08-06-2021
☐ Tdap 08-06-2021
☐ HPV 08-06-2021
☐ Hep B 10-15-2021
☐ Polio 08-06-2021
☐ MMR 08-06-2021
☐ Prevnar 13 02-04-2022
☐ Hep A 10-15-2021
☐ Varicella 08-06-2021
☐ Influenza 08-06-2021
☐ MMRV 08-06-2021
☐ MenB 08-06-2021
☐ MCV4/MPSV4 08-06-2021
☐ Influenza(LIVE)08-06-2021

Authorization to Vaccinate

I have been given a copy of and have read, or had explained to me, the information in the **"Vaccine Information Statements"** for the vaccines indicated above. I understand the benefits and risks of the vaccines and ask that the vaccines be given to me or the person named above for whom I am the authorized to make this request pursuant to

Signature **Date**

ALL SERVICES PROVIDED ON A NON DISCRIMINATORY BASIS

MODIFIED 04-2022 "IF YOU WOULD LIKE A COPY OF OUR NOPP (NOTICE OF PRIVACY POLICY), PLEASE LET US KNOW."

Screening Checklist for Contraindications to HPV, MenACWY, MenB and Tdap Vaccines for Teens

PATIENT NAME _____

DATE OF BIRTH _____ / _____ / _____
MONTH DAY YEAR

For parents/guardians: The following questions will help us determine if human papillomavirus (HPV), meningococcal conjugae (MenACWY), meningococcal serogroup B (MenB), and tetanus, diphtheria, and acellular pertussis (Tdap) vaccines may be given to your teen today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question isn't clear, please ask a nurse to explain it.

		yes	no	don't know
1.	Is the child sick today?	☐	☐	☐
2.	Does your teen have allergies to a vaccine component, or to latex?	☐	☐	☐
3.	Has your teen ever had a serious reaction to a vaccine in the past?	☐	☐	☐
4.	Has your teen had brain or other nervous system problems?	☐	☐	☐
5.	For females: Is your teen pregnant?	☐	☐	☐

VACCINE:	**VACCINE:**	**VACCINE:**
MFR/LOT EXP DATE	MFR/LOT EXP DATE	MFR/LOT EXP DATE
SITE INITIALS	SITE INITIALS	SITE INITIALS
VACCINE:	**VACCINE:**	**VACCINE:**
MFR/LOT EXP DATE	MFR/LOT EXP DATE	MFR/LOT EXP DATE
SITE INITIALS	SITE INITIALS	SITE INITIALS

Signature and Title of Vaccine Administrator **Date Administered and VIS Given**

Signature and Title of Vaccine Administrator **Date Administered and VIS Given**