**Immunization Consent & History: School Immunization Clinics – 11th grade**

Barton County Health Department, 1301 E 12th Street, Lamar, MO 64759 (417) 682-3363

►Check the category(s) that apply to your child (18 years of age or younger). **Return this form** (& **insurance form,** if applicable) to Nurse Diana by **Friday, Feb. 17th**

\_\_\_\_\_ My child has Medicaid OR is eligible for Medicaid **Medicaid # (*Required*)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ My child does not have health insurance **HMO # (*Required*)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ My child has health insurance, but the insurance does not pay for shots (please check your insurance policy)

\_\_\_\_\_ My child is American Indian/Alaskan Native

\_\_\_\_\_ My child has private insurance 🡪 **Fill out the attached insurance information form also**

► Our records show your child is due for the following **\**Required*** & Recommended Vaccines. Please check the vaccine(s) you want your child to receive:

\_\_\_\_\_\***Meningococcal A, C, W, Y (Required)** \_\_\_\_\_\_ **Meningococcal B** (Recommended) – getting both meningococcal vaccines gives the ***best*** protection against meningitis

\_\_\_\_\_ **Human Papilloma Virus** (Recommended) – 3 dose series \_\_\_\_\_ **I do NOT** want my child to participate in the School Immunization Clinic – **Do NOT complete form**

► **Medication & Allergy Information** – Please answer the following:

|  |  |  |
| --- | --- | --- |
| Is your child taking any medications (If yes please list) | Yes | No |
| Is your child allergic to eggs, Neomycin, or any other medications? |  |  |
| **List allergies to medications:** |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **LAST NAME FIRST NAME MI** | | | **DATE OF BIRTH** | | **Sex**  □ Male  □ Female |
| **STREET ADDRESS CITY STATE ZIP CODE** | | |  | **PHONE** | |
| **RACE (SELECT ALL THAT APPLY)**  □ Amer Indian or Alaska Native □ Native Hawaiian or Other Pacific Islander  □ Asian □ White  □ Black or African American | **ETHNICITY**  □ Hispanic or Latino  □ Non-Hispanic or Latino | **♣ PARENT/LEGAL GUARDIAN FULL NAME (Please Print)** | | | |

I have been offered a copy of the *Vaccine Information Statement* (VIS) for the vaccines listed above. I have read, have had explained to me and understand the information in each VIS*.* I ask that the vaccines I have checked above be given to my child named above for whom I am the parent or guardian or am otherwise authorized to make this request.

**I have read the above information and give permission for my child to have the vaccine(s) I selected above, including second and third doses of vaccines as indicated:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Legal Guardian Signature & Date**

**For Barton County Health Department use only:**

**MenQuadfi** **Lot #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Expiration Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Site:** LD RD **Vaccinator** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Bexsero** **Lot #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Expiration Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Site:** LD RD **Vaccinator** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gardasil 9** **Lot #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Expiration Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Site:** LD RD **Vaccinator** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(1/11/2023)