



TRI-COUNTY HEALTH DEPARTMENT
DEKALB-GENTRY-WORTH
302 N. PARK
STANBERRY, MISSOURI 64489
PH. 660-783-2707 FAX: 660-783-2775
MAYSVILLE OFFICE: 816-449-5706

School Vaccine Consent
Child vaccines

Patient Name: _____ Date: _____ F: ☐ M: ☐

DOB: _____ Age: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance _____ Policy # _____ Group # _____

Policy Holder _____ Policy Holder D.O.B. _____

Uninsured? You qualify for State state-provided vaccine and will only need to pay a \$20 admin fee

I, the undersigned, have read or had explained to me the vaccine information sheet (VIS). I understand the risks and benefits associated with the vaccine and have had any questions satisfactorily answered. I voluntarily request that the vaccine be given to me or to the person above for whom I am authorized to make this request and to bill my insurance if applicable. A picture of your Insurance Cards can be texted to 660-822-1247 if you prefer

Signature

Date

Please mark which vaccine(s) you would like to have. If not marked, it will not be administered.

| | | |
|--|--|--|
| <input type="checkbox"/> TDAP <input type="checkbox"/> MCV4 <input type="checkbox"/> Hep A | <input type="checkbox"/> HPV <input type="checkbox"/> MMR <input type="checkbox"/> Varicella | <input type="checkbox"/> Men B <input type="checkbox"/> Polio <input type="checkbox"/> Hep B |
|--|--|--|

Screening Questionnaire

| Questions | Yes | No | Unknown |
|--|-----|----|---------|
| Are you currently ill or do you have a fever? | | | |
| Have you received the vaccine before? | | | |
| Have you had a reaction to the vaccine before? | | | |
| Have you been sick in the last 2 weeks? | | | |
| Have you ever had Guillain-Barre syndrome? | | | |
| Are you pregnant? | | | |
| Are you a Health Care worker? | | | |