JORDAN VALLEY
COMMUNITY HEALTH CENTER

Time Out
☐ Right Drug ☐ Right Route ☐ Right Time
☐ Right Dose ☐ Right Patient

Staff Initial/Date / Time:_____

Immunization Consent Form

Last Name	First Name	MI	Date of Birth	Parent/Guardian Full Name

This patient qualifies for VFC vaccine because:
☐ No insurance ☐ Medicaid enrolled ☐ Insurance does not cover vaccinations ☐ Alaskan Native or Native American ☐ None of these

Please circle yes or no:					
This patient is sick today or has a fever: (Does not include mild cold symptoms or seasonal allergies)	YES	NO	This patient has taken cortisone, prednisone, other steroids, anti-cancer treatments, or had X-Ray treatments in the past 6 months	YES	NO
This patient has had a serious reaction to a vaccine in the past:	YES	NO	This patient or immediate family member has Seizures, brain, nerve problems	YES	NO
This patient has cancer, leukemia, AIDS, or other immune system problem	YES	NO	This patient or immediate family member has Bleeding Disorder	YES	NO
This patient is allergic to medicines, foods, vaccinations	YES	NO	This patient had a transfusion of blood or has been given immune (gamma) globulin in the last 6 weeks	YES	NO
This patient could be pregnant or has a chance she could become pregnant in the next month	YES	NO	This patient has received vaccinations in the last four weeks	YES	NO
This patient has had a serious allergic reaction to chicken eggs; including: hives, swelling of lips or tongue, or difficulty breathing? (Flu only)	YES	NO	This patient has been diagnosed with heart disease, lung disease, asthma, kidney disease, metabolic disease (diabetes), anemia, or other blood disorder? (Flu only)	YES	NO
This patient is 50 years or older.	YES	NO			

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.

_____ _____
Signature of person authorized to make request Date

Vaccine Name *Dose # Given Today*	*Vaccine Name* *Dose # Given Today*	*Vaccine Name* *Dose # Given Today*
Vaccine Manuf/Lot #/Exp Date	*Vaccine Manuf/Lot #/Exp Date*	*Vaccine Manuf/Lot #/Exp Date*
Injection Site & Route R Arm R Leg L Arm L Leg IM SC Oral	*Injection Site & Route* R Arm R Leg L Arm L Leg IM SC Oral	*Injection Site & Route* R Arm R Leg L Arm L Leg IM SC Oral
Vaccine Name *Dose # Given Today*	*Vaccine Name* *Dose # Given Today*	*Vaccine Name* *Dose # Given Today*
Vaccine Manuf/Lot #/Exp Date	*Vaccine Manuf/Lot #/Exp Date*	*Vaccine Manuf/Lot #/Exp Date*
Injection Site & Route R Arm R Leg L Arm L Leg IM SC Oral	*Injection Site & Route* R Arm R Leg L Arm L Leg IM SC Oral	*Injection Site & Route* R Arm R Leg L Arm L Leg IM SC Oral
Vaccine Name *Dose # Given Today*	*Vaccine Name* *Dose # Given Today*	*Vaccine Name* *Dose # Given Today*
Vaccine Manuf/Lot #/Exp Date	*Vaccine Manuf/Lot #/Exp Date*	*Vaccine Manuf/Lot #/Exp Date*
Injection Site & Route R Arm R Leg L Arm L Leg IM SC Oral	*Injection Site & Route* R Arm R Leg L Arm L Leg IM SC Oral	*Injection Site & Route* R Arm R Leg L Arm L Leg IM SC Oral

Signature/ Title / Date of Administration

X_____