JASPER COUNTY HEALTH DEPARTMENT

IN COOPERATION WITH

THE DEPARTMENT OF HEALTH OF MISSOURI

105 LINCOLN - - CARTHAGE, MISSOURI 64836

PHONE: (417) 358-3111 -- FAX: (417) 358-0494

Please check boxes below fill out the consent form and return to front desk.

Do you have:	**Health Insurance**	**YES_____**	**NO_____**	
	Does your Insurance Pay for Shots?	**YES_____**	**NO_____**	
Do you have:	**Medicaid**	**YES_____**	**NO_____**	**DCN # _____**
Are you :	**American Indian**	**YES_____**	**NO_____**	
	Alaskan	**YES_____**	**NO_____**	

LAST NAME	FIRST NAME	MI	SEX ☐ Male ☐ Female	BIRTHDATE	PHONE #

SOCIAL SECURITY #	RACE		ETHNICITY			WIC
	☐ White	☐ Asian or Pacific Islander	☐ Non-Hispanic	☐ Cuban	☐ Unknown	☐ Yes
	☐ Black/African American	☐ Other	☐ Mexicno	☐ Central/South Amer		☐ No
	☐ Indian	☐ Unknown	☐ Puerto Rican	☐ Other & Unk Hispanic		

STREET ADDRESS	CITY	STATE	ZIP CODE

SIGNATURE of person authorized to make the request	DATE
X	

FOR CLINIC USE ONLY

YES _____ NO _____ Has your child ever had a reaction to the Pertussis component of the DTP vaccine?

YES _____ NO _____ Has your child had an injury or accident within the last 10 yrs and received a tetanus shot? If yes, what was the date? _____/_____/_____

I hereby give permission for the Health Nurse to immunize my child, and after reading the information sheet I am aware of possible reactions from the shot. I also understand that the HIPAA Privacy Policy is available for review at the Jasper County Health Department.

X _____

Signature (Parent or Guardian)

Tdap

Clinic ID *Jasper County Health Dept.*
Date Vaccinated
Manuf. & Lot #
Signature/Vacc. Admin.
L or R Deltoid

MCV 4

Clinic ID *Jasper County Health Dept.*
Date Vaccinated
Manuf. & Lot #
Signature/Vacc. Admin.
L or R Deltoid

Td

Clinic ID *Jasper County Health Dept.*
Date Vaccinated
Manuf. & Lot #
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