JASPER COUNTY HEALTH DEPPARTMENT

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	MIDDLE INITIAL	SEX ☐ MALE ☐ FEMALE	BIRTHDATE

PHONE NUMBER	RACE	ETINICITY
	☐ WHITE ☐ ASIAN OR PACIFIC ISLANDER ☐ INDIAN ☐ OTHER ☐ UNKNOWN ☐ AFRICAN AMERICAN/BLACK	☐ NON - HISPANIC ☐ CUBAN ☐ UNKNOWN ☐ MEXICAN ☐ CENTRAL/SOUTH AMERICAN ☐ PUERTO RICANO ☐ OTHER

STREET ADDRESS	CITY	STATE	ZIP CODE

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

✖_____ DATE: _____
SIGNATURE OF PERSON AUTHORIZED TO MAKE THE REQUEST

FOR CLINIC USE ONLY

Tdap	MCV4	Td
CLINIC ID ***JASPER COUNTY HEALTH DEPT***	**CLINIC ID** ***JASPER COUNTY HEALTH DEPT***	**CLINIC ID** ***JASPER COUNTY HEALTH DEPT***
Date Vaccinated	**Date Vaccinated**	**Date Vaccinated**
Manuf. & Lot #	**Manuf. & Lot #**	**Manuf. & Lot #**
Signature/Vacc Admin	**Signature/Vacc Admin**	**Signature/Vacc Admin**
L or R Deltoid	**L or R Deltoid**	**L or R Deltoid**