Randolph County Health Department
1319 E Highway 24, Suite A
Moberly, MO 65270
(660) 263-6643
www.randolphcountyhealth.org

health
DEPARTMENT OF RANDOLPH COUNTY

Immunization Consent

Name	Date of Birth

Parent/Guardian	Phone Number

Address

City	State	Zip Code

Race (Select All that Apply)

- ☐ African American
- ☐ Asian
- ☐ White
- ☐ Native American/ Alaskan Native
- ☐ Other _____
- ☐ Declined

Ethnicity

- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Other _____

Sex

- ☐ Male
- ☐ Female
- ☐ Transgender
- ☐ Non-Binary
- ☐ Other _____

Insurance

- ☐ Medicaid — Medicaid # _____
- ☐ CHIP — ME Code _____

MC+ Plan

- ☐ Healthy Blue
- ☐ Home State Health
- ☐ United Healthcare Community Plan

- ☐ Private Insurance
- ☐ No Insurance
- ☐ **Underinsured (Insurance doesn't cover vaccinations)**
- ☐ Native American/Alaskan Native

Insurance Name	Insurance ID #

Primary Insured Name	Insurance Group #

Relationship to Patient	Primary Insured Date of Birth

I have been given a copy and have read, or had explained to me, the information in the "Vaccine Information Statement(s)," where applicable, for the vaccine(s) indicated. I have had a chance to ask questions and had them answered to my satisfaction. I understand the 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 for whom I am authorized pursuant to Section 431.052, RSMo to make this request.

By signing this form, I am requesting that payment of authorized Medicaid/MC+/Third Party Insurance benefits be made on my behalf to the Randolph County Health Department for any services furnished by their professional staff. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent any information needed to determine these benefits payable for related services.

Patient Signature or Parent/Guardian Signature (if minor)	Date

Printed Name (Patient/Parent/Guardian))

Name of Child)	Date of Birth

Vaccine and Route (Circle type given)	Visit Date	Injection Site	Vaccine Manufacturer/ Lot #	Vaccine Exp. Date	VIS Revision Date	Signature of Vaccine Administrator
Influenza Pediatric IM					8/6/21	
Influenza Reg Dose IM					8/6/21	
Influenza High Dose IM					8/6/21	
PEDIARIX (Dtap/HepB/IPV)					10/15/21	
DTAP					8/6/21	
PENTACEL (Dtap/Hib/IPV)					10/15/21	
KINRIX (Dtap/IPV)					10/15/21	
GARDASIL (HPV)					8/6/21	
HEP B					10/15/21	
HEP A					10/15/21	
HIB					8/6/21	
IPV					8/6/21	
MMR					8/6/21	
PROQUAD (MMR/V)					8/6/21	
TRUMENBA/BEXSERO (Meningococcal B)					8/6/21	
MENQUADFI (MCV4/Meningicoccal)					8/6/21	
PNEUMOVAX 23					10/30/19	
PREVNAR 13					2/4/22	
PREVNAR 20					2/4/22	
ROTARIX/ROTATEQ					10/15/21	
TDAP (Adacel/Boostrix)					8/6/21	
VARIVAX (Varicella)					8/6/21	
SHINGRIX (Shingles)					2/4/22	
VAXELIS					10/15/21	
OTHER _____						
OTHER _____						
OTHER _____						