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CoxHealth
Regional Services
C.A.R.E. MOBILE IMMUNIZATION CONSENT FORM

Name:
Age: DOB: ___/___/_____
AMB:0000
(For Internal Use or Patient Sticker Here)

Child's Legal Name: _____ Birth Date: _____/_____/_____ Sex: Male Female School: _____
Address: _____ City: State _____ Zip:

FINANCIAL OBLIGATION*

** The mission of the C.A.R.E. Mobile program is to provide access to health care for children in the Ozarks who have no insurance, do not have a primary care physician or whose parents cannot afford to pay for necessary services. However, no child will be turned away.*

NO INSURANCE (SELF PAY): _____

PRIMARY INS: _____ **POLICY HOLDER NAME:**

Policy Holder's Employer:
Group #: Policy/ID #: Policy Holder DOB: ___/___/_____

PARENT OR GUARDIAN and EMERGENCY CONTACT INFORMATION

RELATIONSHIP: Father Mother Guardian
Name: (First, MI, Last) Date of Birth: ___/___/_____ Phone Number: _____

VACCINE INFORMATION

Please initial the vaccinations that you would like your child to receive and that are ***required by the State of Missouri*:**
_____DTAP_____Hepatitis B _____Tdap _____Polio _____Varicella _____MMR _____HIB _____Meningococcal

The Mobile Unit offers the following immunizations that are **not required** for school participation, but are **recommended** by the CDC. Please initial the vaccinations you would like your child to receive:
_____HPV _____Flu _____Hepatitis A _____Prevnar 13_____ HIB_____
Vaccine Information Sheets (VIS) are available through the CDC website at http://www.cdc.gov/vaccines/hep/vis/index.html.

SCREENING CHECKLIST FOR CONTRAINDICATIONS TO VACCINES

For parents/guardians - (*Only complete this section if your child is being vaccinated by the C.A.R.E. Mobile*):
The following questions will help us determine which vaccines your child may be given. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

1.	Does the child have allergies to medications, food, a vaccine component, or latex?	YES	NO	UNKNOWN
2.	Has the child had a serious reaction to a vaccine in the past?	YES	NO	UNKNOWN
3.	Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder?	YES	NO	UNKNOWN
4.	Is he/she on long-term aspirin therapy?	YES	NO	UNKNOWN
5.	Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	YES	NO	UNKNOWN
6.	Does the child or a family member have cancer, leukemia, HIV/AIDS, or any other immune system problems?	YES	NO	UNKNOWN
7.	In the past 3 months, has the child taken medications that affect the immune system? such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	YES	NO	UNKNOWN
8.	In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	YES	NO	UNKNOWN
9.	Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	YES	NO	UNKNOWN
10.	Has the child received vaccinations in the past 4 weeks?	YES	NO	UNKNOWN

Please send your child's immunization record card with them on the day of their visit to the C.A.R.E Mobile.
If you would like your child to receive immunizations on the Medical Mobile Unit, please complete this form. All vaccines are provided with no out-of-pocket expense for your child/family. If you do have insurance, CoxHealth will send a bill to your insurance company. You are not responsible for any charges not covered by your insurance company.

Parent Signature: _____ Date: _____

CoxHealth
Regional Services
C.A.R.E. MOBILE REGISTRATION

Name:
Age: DOB: ___/___/_____
AMB:0000
(For Internal Use or Patient Sticker Here)

VACCINE RECORD (FOR C.A.R.E. MOBILE USE ONLY)

Vaccine for Children's Program: _____ Insurance: _____

Vaccine	Brand Name/MFGS	Lot #	EXP	Site	Route	Nurse Administering Vaccine Signature & Credentials	NDC#
Tdap (11-18yo)	Boostrix/GSK				IM		58160-842-52
Dtap/IPV (4-6 yo)	Kinrix/GSK				IM		58160-812-52
Pediarix (DTAP/Pol/HepB)	Pediarix/GSK				IM		58160-811-52
Dtap	Infanrix/ GSK				IM		58160-810-52
MCV4	Menveo/GSK				IM		58160-955-09
HPV	Gardasil/Merck				IM		0006-4121-02
MMR	MMR/Merck				SQ		0006-4681-00
Varicella	Varivax/Merck				SQ		0006-4827-00
MMRV	ProQuad/Merck				SQ		0006-4171-00
IPV	Polio/SP				IM		49281-860-10
Hep A	Havrix/GSK Vaqta/Merck				IM		58160-825-52
PCV 13	Prevnar 13/Pfizer				IM		0005-1971-02
Hep B	Engerix/GSK				IM		58160-820-52
HIB	Pedvax/Merck				IM		0006-4897-00
Nurse Administering Vaccine (Please Print Name):							
School Site:						**Date Given:**	