Health Department
321 E 4th Street
Joplin, MO 64801
417-623-6122

Vaccine Screening Checklist

Please complete form entirely. Please print clearly.

If your insurance is accepted by our billing company, your co-pay will be paid by your insurance company. If you have Medicaid, your co-pay will be paid by Medicaid. If you are uninsured, you will receive state provided vaccine, and *there will be a $13 co-pay (cash or check made out to Joplin City Health Department) per student*.

Student's Last Name	Student's First Name	MI	Student's Date of Birth	Age	Gender ☐ Male ☐ Female
Street Address	City	State	Zip code	Phone	School Attending
Race (Select all that apply) ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White or Caucasian ☐ Native Hawaiian or other Pacific Islander			Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Latino	Parent/Guardian Full Name	
Does student have insurance (Medicaid or private)? Yes No			If yes, DCN/Medicaid number and Managed Care Provider		
Insurance Company			Member ID #		Group #
Insured's Name				Insured's Date of Birth	

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. 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 health care provider to explain it.

	Question	Yes	No	Unknown
1.	Is the child sick today?	☐	☐	☐
2.	Does the child have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3.	Has the child ever had a serious reaction after receiving a vaccination in the past?	☐	☐	☐
4.	Has the child had a health problem with lung, heart, kidney or metabolic disease, asthma, or a blood disorder? Is he/she on blood thinners or long-term aspirin therapy?	☐	☐	☐
5.	Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐	☐	☐
6.	Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
7.	In the past 1 to 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anti-cancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; had radiation treatments?	☐	☐	☐
8.	In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an anti-viral drug?	☐	☐	☐
9.	Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐	☐
10.	Has the child received vaccinations in the past 4 weeks? If so, what was the name of the vaccine and date of service? ______________________________	☐	☐	☐

My child has permission to receive the meningococcal immunization and/or Tdap, and necessary treatment by the Joplin Health Department without a parent present for this immunization clinic.

By signing this form, I consent to the use and disclosure of my medical/ health information for treatment, payment, or health care operations. My child will be given a copy of the Notice of Privacy Practices.
My child will be offered a "Vaccine Information Statement(s)", where applicable, for the vaccine(s) indicated at the time of this vaccination. I understand I can contact the Joplin Health Department to ask questions about this vaccine. I understand the benefits and risks of the vaccine(s) offered, and request that the vaccine(s), for which I have signed below, be given to my child named above for whom I am authorized pursuant to Section 431.058 RSMo to make this request.

Parent/Guardian signature: X____

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For Clinic Use Only

Vaccination Record:

Vaccine given	Date /VIS given	Injection Site	Vaccine Lot #/Mfg	Vaccine expiration	VIS Revision Date	Vaccinator Signature

Vaccine given	Date /VIS given	Injection Site	Vaccine Lot #/Mfg	Vaccine expiration	VIS Revision Date	Vaccinator Signature