Date Stamp
Clinic Site Stamp
V.I.S. Given ( ) Yes

MOBILE COUNTY HEALTH DEPARTMENT
IMMUNIZATION CONSENT

EHS#_____
Chart #_____
Claim #_____

Information about person to receive vaccine (Please print)			
Name: Last First M.I.		D.O.B.	Age
Social Security Number Phone		Race/Ethnicity	Sex M F
Address: Street City State Zip			
☐Yes ☐No Allergies? ☐Yes ☐No History of adverse reactions to vaccines?			
Signature of person to receive vaccine or person authorized to make the request (parent or guardian): Name:_____Date:_____			

Information about responsible party (Please print)	
Name: Last First M.I.	D.O.B.
Social Security Number	Phone
Address: Street	
City State Zip	

This child qualifies for vaccination through the VFC program because he/she **(check only one box):**

- ❒ is enrolled in Medicaid
- ❒ does not have health insurance
- ❒ is American Indian or Native Alaskan
- ❒ has health insurance that does not pay for vaccines (applicable only to children attending a FQHC, RHC, or agent of FQHC)

PAY STATUS

Insurance
____Medicaid
____Medicare
____Other
_____

____Cash
____No Pay
Explain:

____DTaP ____DTap/Hib ____DTap/Hep B/IPV ____DT Ped ____Hep A
____Hep A & B ____Hep B ____Hib ____IPV ____Influenza
____MMR ____MMRV ____Menactra ____Meningococcal ____Pneumonia
____Prevnar ____Rotovirus ____Td ____T-Dap ____Typhoid Vicapsular
____Varicella ____Yellow Fever ____Zostavax ____Other_____

"I have read or have had explained to me information about the vaccine(s) to be given today. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) checked below and ask that the vaccine(s) checked be given to me or to the person named below for whom I am authorized to make this request."

Vaccine:	Vaccine:	Vaccine:	Vaccine:
Manufacturer:	Manufacturer:	Manufacturer:	Manufacturer:
Lot Number:	Lot Number:	Lot Number:	Lot Number:
Injection Site:	Injection Site:	Injection Site:	Injection Site:

Vaccine:	Vaccine:	**NURSE'S NOTES**
Manufacturer:	Manufacturer:	
Lot Number:	Lot Number:	
Injection Site:	Injection Site:	

Signature and Title of Vaccine Administrator:	Provider Stamp:

MCHD-IMM-106 (REV. 6/07)