CoxHealth

CoxHealth CARE Mobile Immunization Packet

The CoxHealth CARE Mobile is partnering with your child's school providing required immunizations per Missouri School requirements, all with the convenience of them being at school. It is not required for you to attend, however you may if you please. Please fill out the paperwork provided in this packet and send back with your student to school and have them turn back into the nurse. I look forward to meeting your student!

- Kelsi, LPN
  CMN Care Coordinator

There is no out of pocket cost.

SPRINGFIELD PUBLIC SCHOOLS

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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: _____ **POLICYHOLDER 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*:**

Incoming Kindergarten Vaccinations:
Kinrix (DTAP/Polio): _____ **Proquad (MMR/Varicella):** _____

Incoming 8th grade Vaccinations:
Meningococcal Conjugate (MCV4):_____ TDAP: _____

Incoming 12th Grade Vaccinations:
Meningococcal Conjugate (MCV4):_____

Others: _____**Prevnar 13** _____ **HIB** _____**Hepatitis B** _____**DTAP**

The Mobile Unit offers the following immunizations that are **not required** for school participation, but **recommended** by the CDC. Please initial the vaccinations you would like your child to receive:

_____**HPV** _____**Flu** _____**Hepatitis A**

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: _____