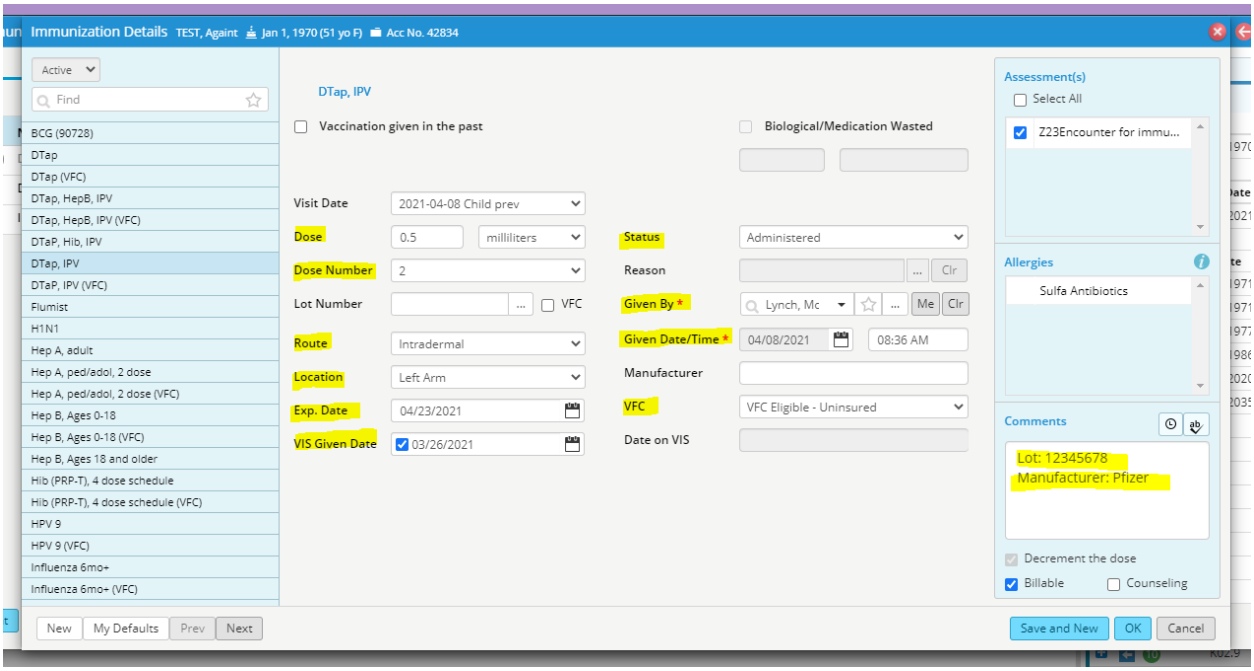
Immunization Documentation Process

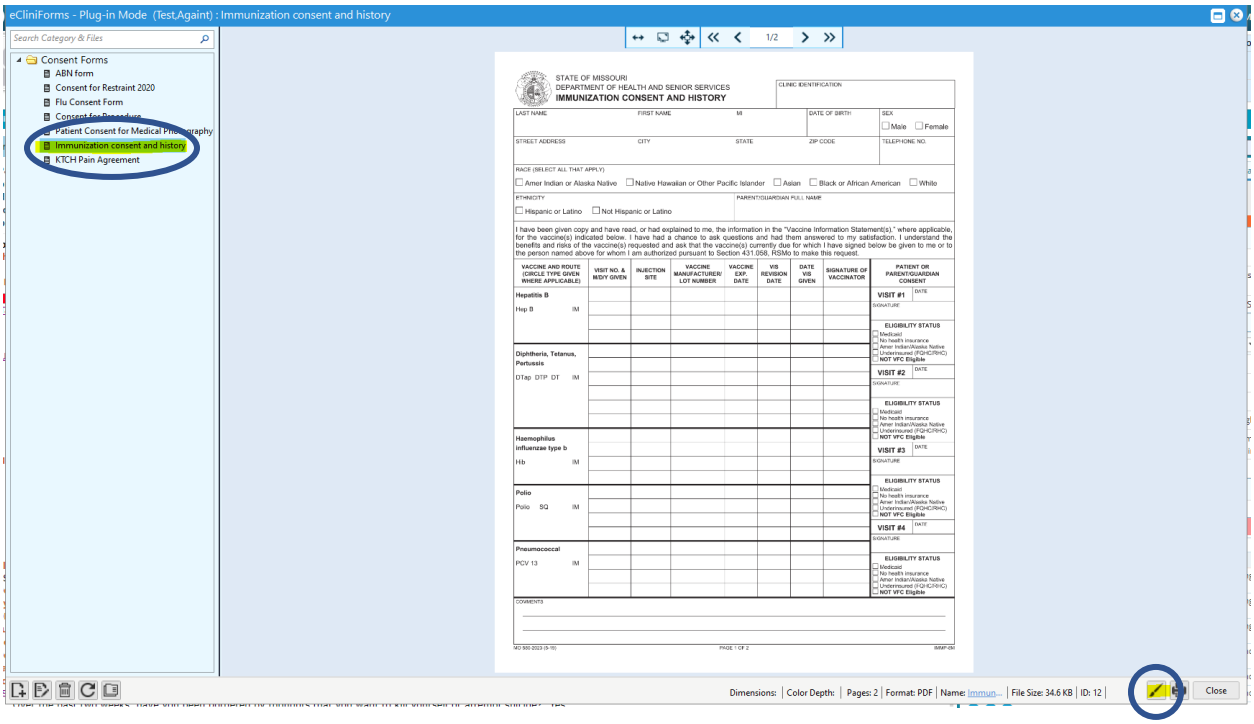
1. Nursing team member will Open *Imm* module within progress note of current encounter.
2. Select Add
3. Find specific immunization(s)
4. Document and/or verify required immunization fields:
    a. Dose
    b. Dose number
    c. Route
    d. Location
    e. Exp Date
    f. VIS Given Date
    g. Status
    h. Given By
    i. VFC
    j. Lot Number (comment section)
    k. Manufacturer (comment section)



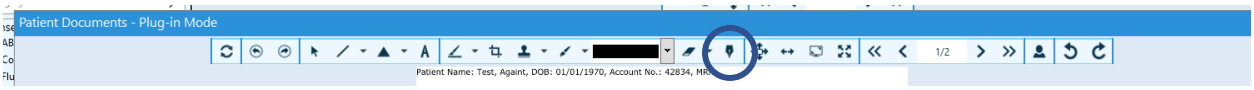
5. Select *OK* to save and continue or *Save & New* to save and document an additional immunization.
6. Select *Ink* at bottom of progress note
7. Select the *Immunization Consent & History Form*

Immunization Documentation Process

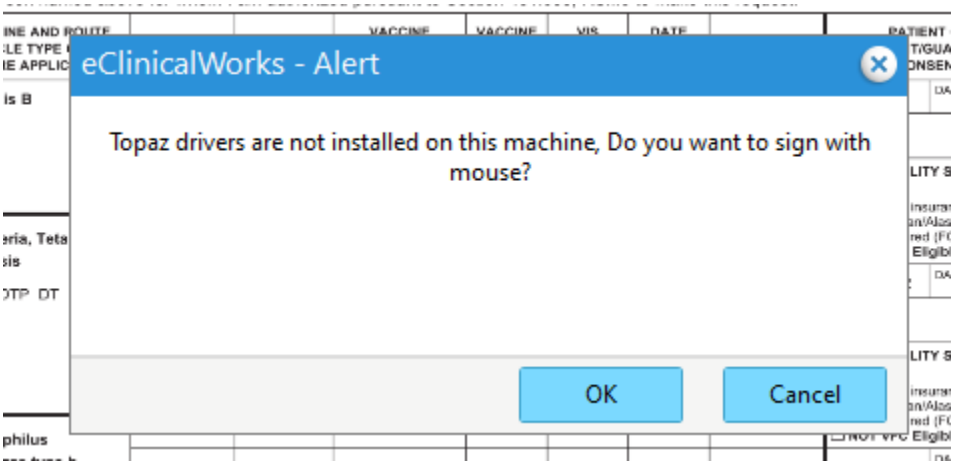
8. Select the *Ink Edit* button on the bottom left of the screen



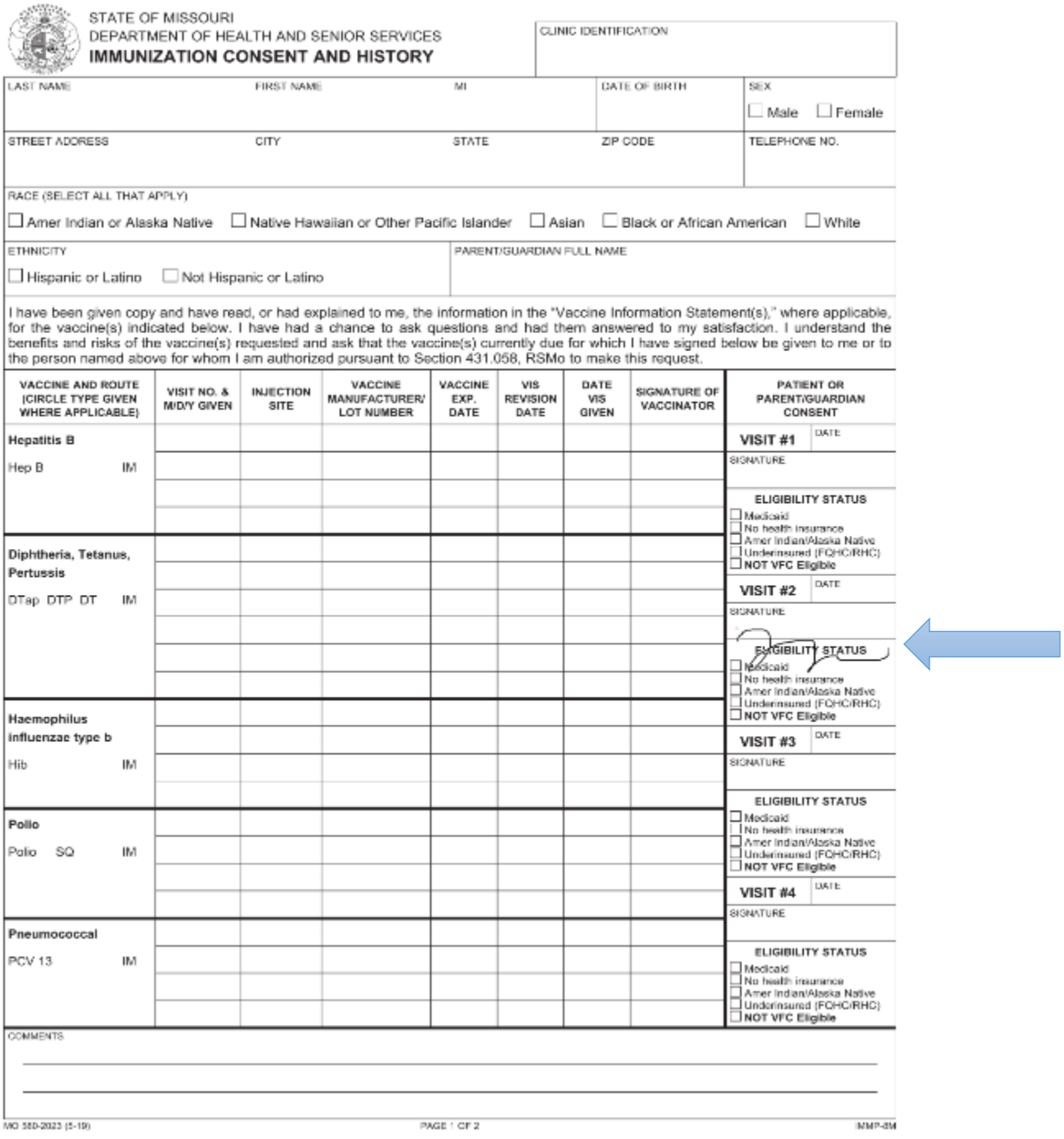
9. Click once where the signature will need to populate on the form
10. Select the *signature* icon in the top toolbar.



11. Select “OK” on the alert regarding Topaz drivers.



12. Patient can now sign on the computer screen with a stylus or their finger.



STATE OF MISSOURI
DEPARTMENT OF HEALTH AND SENIOR SERVICES
IMMUNIZATION CONSENT AND HISTORY

CLINIC IDENTIFICATION

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SEX
				☐ Male ☐ Female

STREET ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NO.

RACE (SELECT ALL THAT APPLY)
☐ Amer Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ Black or African American ☐ White

ETHNICITY
☐ Hispanic or Latino ☐ Not Hispanic or Latino

PARENT/GUARDIAN FULL NAME

I have been given copy and have read, or had explained to me, the information in the "Vaccine Information Statement(s)," where applicable, for the vaccine(s) indicated below. I have had a chance to ask questions and had them answered to my satisfaction. I understand the benefits and 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 above for whom I am authorized pursuant to Section 431.058, RSMo to make this request.

VACCINE AND ROUTE (CIRCLE TYPE GIVEN WHERE APPLICABLE)	VISIT NO. & M/D/Y GIVEN	INJECTION SITE	VACCINE MANUFACTURER/ LOT NUMBER	VACCINE EXP. DATE	VIS REVISION DATE	DATE VIS GIVEN	SIGNATURE OF VACCINATOR	PATIENT OR PARENT/GUARDIAN CONSENT
Hepatitis B Hep B IM								VISIT #1 DATE SIGNATURE ELIGIBILITY STATUS ☐ Medicaid ☐ No health insurance ☐ Amer Indian/Alaska Native ☐ Underinsured (FQHC/RHC) ☐ NOT VFC Eligible
Diphtheria, Tetanus, Pertussis DTap DTP DT IM								VISIT #2 DATE SIGNATURE ELIGIBILITY STATUS ☐ Medicaid ☐ No health insurance ☐ Amer Indian/Alaska Native ☐ Underinsured (FQHC/RHC) ☐ NOT VFC Eligible
Haemophilus influenzae type b Hib IM								VISIT #3 DATE SIGNATURE ELIGIBILITY STATUS ☐ Medicaid ☐ No health insurance ☐ Amer Indian/Alaska Native ☐ Underinsured (FQHC/RHC) ☐ NOT VFC Eligible
Polio Polio SQ IM								VISIT #4 DATE SIGNATURE ELIGIBILITY STATUS ☐ Medicaid ☐ No health insurance ☐ Amer Indian/Alaska Native ☐ Underinsured (FQHC/RHC) ☐ NOT VFC Eligible
Pneumococcal PCV 13 IM								

COMMENTS

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Patient Name: Test, Againt, DOB: 01/01/1970, Account No.: 42834, MRN: