VACCINE DOCUMENTATION/CONSENT FORM

I have been offered a copy of the Vaccine Information Statement(s) (VIS) checked below. I have read, had explained to me, and understand the information in the VIS(s). I ask that the vaccine(s) checked below be given to me or to the person named below for whom I am authorized to make this request. I consent to inclusion of this immunization data in the Kansas Immunization Registry for myself or on behalf of the person named below.

☐ DT ☐ DTaP ☐ Tdap ☐ Td ☐ HepA ☐ HepB ☐ Hib ☐ HPV ☐ Influenza ☐ Meningococcal

☐ MMR ☐ PCV7 ☐ PPV23 ☐ Polio/IPV ☐ Rotavirus ☐ Varicella ☐ Other____________

____ Signature of Patient or Parent/Guardian

_______________ Date

PATIENT INFORMATION				
Patient's Last Name: **Patient's First Name:**	**Phone Number:**	**Age:**	**Birth date:**	
Street Address:	**City:**	**County:**	**State:**	**Zip Code:**

Ethnicity: Hispanic or Latino
___ Yes ___ No

Gender
___ Male ___ Female

Race: (Select one or more.)
___ AS-Asian/Pacific Islander/Other
___ BL-Black or African American
___ CA-Caucasian/Mexican/Puerto Rican
___ CH-Chinese
___ FI-Filipino
___ HA-Hawaiian
___ IN-Native American/Alaska Native
___ JA-Japanese
___ NW-Other Non-White
___ UN-Unknown

Primary Care Physician:	**Street Address:** **City:**	**State:** **Zip:**	**Phone:** **Fax:**

PATIENT ELIGIBILITY

__Medicaid	__No health insurance	__Native Am/Alaska Native	__Underinsured*^	__Underserved**^	__HealthWave	__Fully Insured

*Underinsured children: insurance does not cover immunizations, are eligible through VFC program if vaccinated at a FQHC or RHC.
**Underserved children: children have insurance co-pay or deductible high enough to provide a barrier to immunizations.
^ Underserved and Underinsured children are eligible through state funded vaccine program if vaccinated at a public county health clinic.

IMMUNIZATION SCREENING QUESTIONNAIRE	
1. Is the person to be vaccinated currently sick or experiencing a high fever?	__yes __no
2. Has the person to be vaccinated had a serious reaction to a vaccine in the past?	__yes __no
3. Does the person to be vaccinated have any allergies that produce a severe (anaphylactic) reaction?	__yes __no
4. Has the person to be vaccinated had a seizure or other neurological problem?	__yes __no
5. Does the person to be vaccinated have any medical problems that make it hard for him/her to fight infection?	__yes __no
6. Does the person to be vaccinated have close, regular contact with someone with a weakened immune system?	__yes __no
7. Is the person taking cortisone, prednisone, other steroids, or anti-cancer drugs, or had x-ray treatments?	__yes __no
8. Has the person to be vaccinated received blood, plasma, or immune globulin in the past twelve months?	__yes __no
9. Is the person to be vaccinated pregnant or thinking of becoming pregnant within the next three months?	__yes __no

NAME________________________________ AGE________ DOB_________

PROVIDER INFORMATION					
Vaccine Provider:			Clinic Site:		
Street Address:	State:	Zip Code:	Street Address:	State:	Zip Code:

(Circle the appropriate vaccine, dose, extremity, site, route, and enter the manufacturer, lot #, and expiration date.)

FOR CLINICAL USE ONLY							
VACCINE	**DOSE**	**EXT**	**SITE**	**ROUTE**	**VIS DATE**	**MANUFACTURER LOT #**	**EXP DATE**
DTaP DT Td Tdap	1 2 3 4 5 6	RT LT	Deltoid Vastus Lat	IM			
DTaP/IPV	1 2 3	RT LT	Deltoid Vastus Lat	IM			
DTaP/HepB/IPV	1 2 3	RT LT	Deltoid Vastus Lat	IM			
DTaP/Hib/IPV	1 2 3	RT LT	Deltoid Vastus Lat	IM			
DTaP/Hib	4	RT LT	Deltoid Vastus Lat	IM			
Hep A	1 2 3	RT LT	Deltoid Vastus Lat	IM			
Hep B	1 2 3	RT LT	Deltoid Vastus Lat	IM			
Hep B/Hib	1 2 3	RT LT	Deltoid Vastus Lat	IM			
Hib	1 2 3 4	RT LT	Deltoid Vastus Lat	IM			
HPV	1 2 3	RT LT	Deltoid	IM			
Influenza	1 2	RT LT	Deltoid Vastus Lat	IM			
MCV4	1	RT LT	Deltoid	IM			
MMR	1 2	RT LT	Upper Arm Thigh	SQ			
MMR-V	1 2	RT LT	Upper Arm Thigh	SQ			
PCV7	1 2 3 4	RT LT	Deltoid Vastus Lat	IM			
Polio/IPV	1 2 3 4	RT LT	Upper Arm Thigh	SQ			
PPV23	1 2	RT LT	Deltoid Vastus Lat	IM			
Rotavirus	1 2 3		By Mouth	Oral			
Varicella	1 2	RT LT	Upper Arm Thigh	SQ			
Other							

Signature and Title of Vaccine Administrator

Date