IMMUNIZATION ADMINISTRATION CHART - CHILD

Clinic/Provider Name & Address:

NAME: BIRTHDATE: M F

ADDRESS: CITY: STATE: ZIP: PHONE #:

I agree to allow this health care provider to release information on vaccinations given to me, or to the person for whom I am authorized to consent, to the Kansas Immunization Program, other health care providers, and schools to avoid the need for unnecessary repeat vaccinations and to provide information on what immunizations have been received. I understand I am not required to agree to the release of this information in order to receive vaccinations today.

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.

VACCINE (CIRCLE CHOICE)	DATE GIVEN	SIGNATURE OF RECIPIENT OF VACCINE OR PERSON AUTHORIZED TO REQUEST	VACCINE MANUF.	VACCINE LOT NO.	EXP DATE	SITE GIVEN	NAME/TITLE OF ADMINISTRATOR	VIS PUB DATE	VFC/CHD CODES
DTaP/DTP/DT1						LVL RVL LD RD			
DTaP/DTP/DT2						LVL RVL LD RD			
DTaP/DTP/DT3						LVL RVL LD RD			
DTaP/DTP/DT4						LD RD			
DTaP/DTP/DT5						LD RD			
Td						LD RD			
Td						LD RD			
Td or Tdap						LD RD			
Polio 1						LSQ RSQ ORAL			
Polio 2						LSQ RSQ ORAL			
Polio 3						LSQ RSQ ORAL			
Polio 4						LSQ RSQ ORAL			
MMR/MMR-V 1						LSQ RSQ			
MMR/MMR-V 2						LSQ RSQ			
Hib 1						LVL RVL LD RD			
Hib 2						LVL RVL LD RD			
Hib 3						LVL RVL LD RD			
Hib 4						LD RD			
Hep A						LVL RVL LD RD			
Hep A 2						LVL RVL LD RD			
Hep B 1						LVL RVL LD RD			
Hep B 2						LVL RVL LD RD			
Hep B 3						LVL RVL LD RD			
HPV						LVL RVL LD RD			
HPV						LVL RVL LD RD			
HPV						LVL RVL LD RD			
Varicella 1						LSQ RSQ			
Varicella 2						LSQ RSQ			
Pneumo-conj 1						LVL RVL LD RD			
Pneumo-conj 2						LVL RVL LD RD			
Pneumo-conj 3						LVL RVL LD RD			
Pneumo-conj 4						LVL RVL LD RD			
Pneumo-conj 5						LVL RVL LD RD			
Meningo-conj 1						LD RD			
Meningo-conj 2						LD RD			
Rotavirus 1						ORAL			
Rotavirus 2						ORAL			
Rotavirus 3						ORAL			

ES: 1 = T19-MED, 2 = Uninsured, 3 = Native American or Alaskan Native, 4 = T21-SCHIP, 5 = Under Insured (RHC/FQHC only)

CHD CODES: 6 = Under Served, 7 = Under Insured (RHC/FQHC only)

IMMUNIZATION ADMINISTRATION CHART - ADULT

Clinic/Provider Name & Address:

NAME:		**BIRTHDATE:**	
I.D. NUMBER:	**M F**	**TELEPHONE NUMBER:**	
ADDRESS:		**CITY:**	**STATE:** **ZIP:**

I agree to allow this health care provider to release information on vaccinations given to me, or to the person for whom I am authorized to consent, to the Kansas Immunization Program, other health care providers, and schools to avoid the need for unnecessary repeat vaccinations and to provide information on what immunizations have been received. I understand I am not required to agree to the release of this information in order to receive vaccinations today.

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.

VACCINE (CIRCLE CHOICE)	DATE GIVEN	SIGNATURE OF RECIPIENT OF VACCINE OR PERSON AUTHORIZED TO REQUEST	VACCINE MANUF.	VACCINE LOT NO.	EXP DATE	SITE GIVEN	NAME/TITLE OF ADMINISTRATOR	VIS PUB DATE
Td						LD RD		
Td						LD RD		
Td or Tdap						LD RD		
IPV 1						LD RD		
IPV 2						LD RD		
IPV 3						LD RD		
MMR						LSQ RSQ		
MMR						LSQ RSQ		
Influenza 1						LD RD		
Influenza 2						LD RD		
Influenza 3						LD RD		
Influenza 4						LD RD		
Pneumococcal 1						SQ or IM		
Pneumococcal 2						SQ or IM		
Meningo-conj 1						LD RD		
Meningo-conj 2						LD RD		
Hep A 1						LD RD		
Hep A 2						LD RD		
Hep B 1						LD RD		
Hep B 2						LD RD		
Hep B 3						LD RD		
HPV						LD RD		
HPV						LD RD		
HPV						LD RD		
Varicella 1						LSQ RSQ		
Varicella 2						LSQ RSQ		
OTHER IMMUNIZATIONS								
Typhoid								
Cholera								
Yellow Fever								
Other								

TB TEST	DATE GIVEN	SIGNATURE OF PROVIDER	DATE READ	RESULT	TEST	DATE GIVEN	SIGNATURE OF PROVIDER	DATE READ	RESULT