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 MCV4/MenB

MMR PCV13 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						
__T19-MED	__No health insurance	__Native Am/Alaska Native	__Underinsured*	__Underserved**	__T21-SCHIP	__Fully Insured

*Underinsured children: insurance does not cover immunizations. Eligible through VFC program if vaccinated at a FQHC, RHC or delegated county health department.
**Underserved (State) children: Are not VFC eligible. May only be vaccinated with KIP vaccines needed at school (K-12) entry at a county health department if enrolled in federal free or reduced-price school lunch program.

IMMUNIZATION SCREENING QUESTIONNAIRE	
1. Is the patient to be vaccinated currently sick or experiencing a high fever?	☐_yes ☐ no
2. Does the patient have allergies to medications, food, a vaccine component, or latex?	☐_yes ☐ no
3. Has the patient had a serious reaction to a vaccine in the past?	☐_yes ☐ no
4. Has the patient had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	☐_yes ☐ no
5. If the patient to be vaccinated is between the ages of 2 and 4 years, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐_yes ☐ no
6. If the patient is a baby, have you ever been told he or she has had intussusceptions?	☐_yes ☐ no
7. Has the patient, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐_yes ☐ no
8. Does the patient have cancer, leukemia, HIV/AIDS, or any other immune system problem	☐_yes ☐ no
9. In the past 3 months, has the patient taken medications that weaken their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?	☐_yes ☐ no
10. In the past year, has the patient received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐_yes ☐ no
11. Is the patient pregnant or is there a chance she could become pregnant during the next month?	☐_yes ☐ no
12. Has the patient received vaccinations in the past 4 weeks?	☐_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	0.5 mL 1 2 3 4 5 6	RT LT	Deltoid Vastus Lat	IM			
DTaP/IPV	0.5 mL 5th DTaP--4th IPV	RT LT	Deltoid Vastus Lat	IM			
DTaP/HepB/IPV	0.5 mL 1 2 3	RT LT	Deltoid Vastus Lat	IM			
DTaP/Hib/IPV	0.5 mL 1 2 3 4	RT LT	Deltoid Vastus Lat	IM			
Hep A	0.5 mL 1.0 mL 1 2	RT LT	Deltoid Vastus Lat	IM			
Hep B	0.5 mL 1.0 mL 1 2 3	RT LT	Deltoid Vastus Lat	IM			
Hep B/Hib	0.5 mL 1 2 3	RT LT	Deltoid Vastus Lat	IM			
Hib	0.5 mL 1 2 3 4	RT LT	Deltoid Vastus Lat	IM			
HPV	0.5 mL 1 2 3	RT LT	Deltoid	IM			
Influenza LAIV4 IIV3 IIV4	0.1mL 0.2mL 0.25mL 0.50mL 1 2	RT LT	Upper Arm Deltoid Vastus Lat	Intradermal Intranasal IM			
MCV4	0.5 mL 1 2	RT LT	Deltoid	IM			
MENB	0.5 mL 1 2 3	RT LT	Deltoid	IM			
MMR	0.5 mL 1 2	RT LT	Upper Arm Thigh	SC			
MMR-V	0.5 mL 1 2	RT LT	Upper Arm Thigh	SC			
PCV13	0.5 mL 1 2 3 4	RT LT	Deltoid Vastus Lat	IM			
Polio/IPV	0.5 mL 1 2 3 4 5	RT LT	Upper Arm Thigh	IM SC			
PPV23	0.5 mL 1 2	RT LT	Upper Arm Deltoid Vastus Lat	SC IM			
Rotavirus	2.0 mL 1 2 3		By Mouth	Oral			
Varicella	0.5 mL 1 2	RT LT	Upper Arm Thigh	SC			
Other							

____ ______________

Signature and Title of Vaccine Administrator Date