

Vaccine Documentation/ Consent Form



PATIENT INFORMATION			
Patient's Last Name: _____		Patient's First Name: _____	
Phone Number: _____		Date of Birth: _____	Responsible Party Social Security #: _____
Street Address: _____		City: _____	County: _____ State: _____ Zip: _____
Ethnicity: Hispanic or Latino: <input type="checkbox"/> Yes <input type="checkbox"/> No		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Race: (Select one or more)		<input type="checkbox"/> AS-Asian <input type="checkbox"/> HA-Hawaiian/Pacific Islander/Other <input type="checkbox"/> BL-Black or African American <input type="checkbox"/> IN-Native American/Alaska Native <input type="checkbox"/> CA-Caucasian/White <input type="checkbox"/> HI - Mexican/Puerto Rican <input type="checkbox"/> NW-Other <input type="checkbox"/> UN-Unknown	
Primary Care Physician: _____		Phone #: _____	City & State: _____

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

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.

Signature of Patient or Parent/Guardian

Date

* OFFICE USE ONLY * VFC 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 free or reduced-price school lunch program.*