Vaccine Documentation/ Consent Form

PUBLIC HEALTH Franklin COUNTY KANSAS EST. 1855

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: ❑ 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 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

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***

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Name: _____ **Date of Birth:** _____

(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			
Dtap/IPV/HIB/Hep B	0.5 mL 1 2 3	RT LT	Deltoid Vastus Lat	IM			
HepA	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			
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	 1 2	RT LT	Deltoid Vastus Lat	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	SC			
MMR-V	0.5 mL 1 2	RT LT	Upper Arm	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 Vastus Lat	IM SC			
PCV20	0.5 mL 1 2	RT LT	Deltoid	IM			
Rotavirus	2.0 mL 1 2 3		By Mouth	Oral			
Shingles	0.5 mL 1 2	RT LT	Deltoid	IM			
Varicella	0.5 mL 1 2	RT LT	Upper Arm	SC			
Other							