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 ☐ PCV7/13 ☐ 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. Eligible through VFC program if vaccinated at a FQHC, RHC or county health department.
**Underserved children: Are not VFC eligible. May only be vaccinated with KIP vaccines needed at school entry at a county health department if enrolled in federal free or reduced-price school lunch program.

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	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/Hib	0.5 mL 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 LAIV TIV	0.1mL 0.2mL 0.25mL 0.50mL 1 2	RT LT	Forearm Deltoid Vastus Lat	Intradermal Intranasal IM			
MCV4	0.5 mL 1 2	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			
PCV7/13	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