

## 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     PCV13     PPV23     Polio/IPV     Rotavirus     Varicella     Other\_\_\_\_\_

\_\_\_\_\_

Signature of Patient or Parent/Guardian

\_\_\_\_\_

Date

PATIENT INFORMATION						
<b>Patient's Last Name:</b>		<b>Patient's First Name:</b>		<b>Phone Number:</b>		<b>Age:</b>
<b>Birth date:</b>		<b>Street Address:</b>		<b>City:</b>		<b>County:</b>
<b>State:</b>		<b>Zip Code:</b>		<b>Race:</b> (Select one or more.)		
<b>Ethnicity:</b> Hispanic or Latino <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> AS-Asian/Pacific Islander/Other		<input type="checkbox"/> HA-Hawaiian		
<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> BL-Black or African American		<input type="checkbox"/> IN-Native American/Alaska Native		
		<input type="checkbox"/> CA-Caucasian/Mexican/Puerto Rican		<input type="checkbox"/> JA-Japanese		
		<input type="checkbox"/> CH-Chinese		<input type="checkbox"/> NW-Other Non-White		
		<input type="checkbox"/> FI-Filipino		<input type="checkbox"/> UN-Unknown		
<b>Primary Care Physician:</b>		<b>Street Address:</b>		<b>State:</b>		<b>Phone:</b>
		<b>City:</b>		<b>Zip:</b>		<b>Fax:</b>
PATIENT ELIGIBILITY						
<input type="checkbox"/> T19-MED	<input type="checkbox"/> No health insurance	<input type="checkbox"/> Native Am/Alaska Native	<input type="checkbox"/> Underinsured*	<input type="checkbox"/> Underserved**	<input type="checkbox"/> T21-SCHIP	<input type="checkbox"/> 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			
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 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			
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							

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Signature and Title of Vaccine Administrator\_\_\_\_\_  
Date