Private VFC 317

Pratt County Health Department
VACCINE DOCUMENTATION/CONSENT FORM

I have been offered a copy of the Vaccine Information Statement(s) (VIS) or Emergency Use Authorization (EUA) fact sheets(s) marked below. I have read, had explained to me, and understand the information in the fact sheets. I ask that the vaccine(s) marked below be administered to me or to the minor named below, for whom I am legally authorized to make this request. I consent for inclusion of this immunization data in the Kansas Immunization Registry for myself or on behalf of the person named below.

Pentacel - (Dtap/IPV/Hib) **Vaxelis** - (Dtap/IPV/Hib/HepB) **Quadracel** - (Dtap/IPV)

DTaP **HepA** **HepB** **Hib** **HPV** **MenACWY** **MenB** **MMR** **MMRV** **PCV20** **Polio/IPV**

Rotavirus **RSV** **Shingrix** **Tdap** **Varicella** **COVID-19** **Influenza** **Other**_____

For Patient to Complete - PATIENT INFORMATION				
Patient's Legal Last Name: **Legal First Name:**		**Phone Number:**	**Age:**	**Date of Birth:**
Mailing Address:	**City:**	**County:**	**State:**	**Zip Code:**

Ethnicity: (Circle One) Hispanic or Latino YES NO **Gender:** MALE FEMALE OTHER: Self-Describe as _____	**Race: (**Select one or more.) ___ American Indian/Alaska Native ___ Asian ___ Black or African American ___ White or Caucasian ___ Native Hawaiian or Other Pacific Islander ___ Other Non-White ___ Unknown		
Primary Care Physician:	**Physician Address:** **City:**	**State:** **Zip:**	**Phone:** **Fax:**

FOR OFFICE USE - 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.

For Patient to Complete - IMMUNIZATION SCREENING QUESTIONNAIRE	Circle One
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, or a sibling/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

X _____ _____

Signature of Patient or Parent/Guardian Date

PROVIDER INFORMATION			
Medical Director: Dr. Aaron Zook		Clinic Site: Pratt County Health Department	
Street Address: 712 S. Main St. Pratt, KS 67124	Phone Number: 620 672-4135	Street Address: 712 S. Main St. Pratt, KS 67124	Phone Number: 620 672-4135

(Circle the appropriate vaccine, dose, extremity, site, route, and enter the manufacturer, lot #, and expiration date.)

FOR CLINIAL USE ONLY:

VACCINE	DOSE	EXT	SITE	ROUTE	VIS DATE	MANUFACTURER LOT #	EXP DATE
DTaP Tdap	0.5 mL	RT LT	Deltoid Vastus Lat	IM			
Quadracel DTaP/IPV	0.5 mL	RT LT	Deltoid Vastus Lat	IM			
Vaxelis DTaP/Hib/IPV/HepB	0.5 mL	RT LT	Deltoid Vastus Lat	IM			
Pentacel DTaP/Hib/IPV	0.5 mL	RT LT	Deltoid Vastus Lat	IM			
Hep A	0.5 mL 1.0 mL	RT LT	Deltoid Vastus Lat	IM			
Hep B	0.5 mL 1.0 mL	RT LT	Deltoid Vastus Lat	IM			
Hib	0.5 mL	RT LT	Deltoid Vastus Lat	IM			
HPV	0.5 mL	RT LT	Deltoid Vastus Lat	IM			
Influenza Regular HD	0.5mL 0.7mL	RT LT	Deltoid Vastus Lat	IM			
MCV4	0.5 mL	RT LT	Deltoid Vastus Lat	IM			
MenB	0.5 mL	RT LT	Deltoid	IM			
Live Virus MMR	0.5 mL	RT LT	Upper Arm	SC			
Live Virus MMRV	0.5 mL	RT LT	Upper Arm	SC			
Prevnar 20	0.5 mL	RT LT	Deltoid Vastus Lat	IM			
Polio/IPV	0.5 mL	RT LT	Deltoid	IM SC			
Rotavirus	2.0 mL		By Mouth	Oral			
RSV	0.5 mL 1.0 mL	RT LT	Deltoid Vastus Lat	IM			
Shingrix	0.5 mL	RT LT	Deltoid	IM			
Live Virus Varicella	0.5 mL	RT LT	Upper Arm	SC			

Signature and Title of Vaccine Administrator

Date