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 MCV4/MenB

MMR PCV13 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						
__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 i
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