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 the person named below for whom I the parent or guardian or am otherwise 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. I have been offered a copy of the McPherson County Health Department Notice of Privacy Practices effective January 1 of the current year. I authorize payment of medical benefits to McPherson County Health Department and agree to be personally and fully responsible for payment of expenses not covered by my insurance.

DTaP/DT/TDaP/TD HepA HepB Hib HPV Influenza Meningococcal PCV13 PPV23 Polio/IPV Rotavirus TB ppd Varicella Other _____

_____ _____

Signature of Patient or Parent/Guardian Date

Patient Last Name	Patient First Name	Middle Initial	Maiden/Alternate Name	Birth Date	Age

Street Address	City	County	State	Zip Code	Social Security	Phone Number

Ethnicity (Hispanic or Latino) ___ Yes ___ No **Gender** ___ Male ___ Female	Race (Check one or more) ___AS-Asian/Pacific Islander/Other ___HA-Hawaiian ___BL-Black/African American ___IN-Native American/Alaska Native ___CA-Caucasian/Mexican/Puerto Rican ___JA-Japanese ___CH-Chinese ___FI-Filipino ___NW-Other Non-White ___UN-Unknown	Primary Care Physician

Name, DOB, and SSN of Insurance Carrier (If different than patient)	Full name, address and relationship to patient of person responsible for payment (if other than patient)

Father's Name	Birth Date	SSN	Age	Phone

Address	City	State	Zip Code

Mother's Name	Birth Date	SSN	Age	Phone

Address	City	State	Zip Code

Please circle yes or no for each question:

1.	Is the patient to be vaccinated currently sick or experiencing a high fever?	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
2.	Does the patient have allergies to medications, food, a vaccine component, or latex?	Yes No	8.	Does the patient have cancer, leukemia, HIV/AIDS, or any other immune system problem?	Yes No
3.	Has the patient had a serious reaction to a vaccine in the past?	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
4.	Has the patient had a health problem with lung, heart, kidney or metabolic disease, asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	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
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 year?	Yes No	11.	Is the patient pregnant or is there a chance she could become pregnant during the next month?	Yes No
6.	If your patient is a baby, have you ever been told he or she has had intussusceptions?	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							

_____ _____

Signature and Title of Vaccine Administrator Date