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 am the parent or guardian or am otherwise authorized to make this request. I consent to the 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.

Influenza

_____ _____

Signature of Patient or Parent/Guardian Date

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

Street Address	City	State	Zip Code	Social Security	Phone Number

Ethnicity (Hispanic or Latino)	Race (Check one or more)	Primary Care Physician
___ Yes ___ No Gender ___ Male ___ Female ___ Other	__ Asian/Pacific Islander/Other __ Hawaiian __ Black/African American __ Native American/Alaska Native __ Caucasian/Mexican/Puerto Rican __ Japanese __ Chinese __ Filipino __ Other Non-White __ Unknown	

Insurance Carrier Name, DOB and Social Security Number (if different from patient)	Name, address and relationship of person responsible for payment (if other than patient)

Parent/Guardian Name	Birth Date	Social Security Number	Age	Phone Number

Address	City	State	Zip Code

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 be 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

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Type: Public Private **Site**: LA RA LVL RVL **Dose/Lot**:

Revised 9/2020