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.

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	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 ___BL-Black/African American ___CA-Caucasian/Mexican/Puerto Rican ___CH-Chinese ___FI-Filipino ___NW-Other Non-White ___HA-Hawaiian ___IN-Native American/Alaska Native ___JA-Japanese ___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

Nurse/Staff Use Only Below

Dose: 1 2 Lot# _____

Side: L R Expiration _____

Site: Delt Vast Lat

Dosage: 0.5mL 0.25mL

_____ _____

Signature and Title of Vaccine Administrator Date

Revised 09/2018