

# VACCINE DOCUMENTATION AND CONSENT FORM

Rev.2/2018

- DTaP    Hep A    Hep B    HIB    HPV    Influenza (Flu)    IPV    MCV4    Men B  
MMR    PCV13    PPSV23    Rotavirus    Td    Tdap    Typhoid    Varicella    Zoster

NAME (Last)		(First)		(M.I.)	
BIRTHDAY (DOB)		AGE		GENDER M / F	PHONE
ADDRESS			CITY		STATE
RACE White   Black   American Indian   Asian	ETHNICITY Hispanic   Non-Hispanic		MARITAL STATUS Married   Divorced   Single   Widow		DOCTOR'S NAME:

### IMMUNIZATION SCREENING QUESTIONS

1. Is the person to be vaccinated sick today or experiencing a fever? If yes, describe illness.	___ Yes   ___ No
2. Has the person to be vaccinated ever had an allergy to any <u>food, medication or vaccine</u> that produced a <u>life-threatening</u> reaction? If yes, what:	___ Yes   ___ No
3. Does the person to be vaccinated have a severely weakened immune system due to illness or is the person currently receiving cancer treatments with radiation or drugs?	___ Yes   ___ No
4. Has the person to be vaccinated received a gamma globulin (Immune Globulin) injection or received blood products such as packed RBC's, platelets, factor 8, plasma or whole blood in the last 12 months?	___ Yes   ___ No
5. Has the person to be vaccinated taken any immune suppressing medications (ex: Methotrexate, Prednisone, Humira) or <b>For Children and Teens: Do they take a daily aspirin?</b>	___ Yes   ___ No
6. Does the person to be vaccinated have any long term health problems: <b>autoimmune disorder (lupus, RA), lung (asthma/wheezing/reactive airway), diabetes, heart, kidney, liver disease, anemia, HIV? (circle which applies)</b>	___ Yes   ___ No
7. Does the person to be vaccinated have a history of convulsions or other neurological problems, or a history of low platelet count?	___ Yes   ___ No
8. Has the person to be vaccinated received any vaccinations within the last 28 days? If yes, what:	___ Yes   ___ No
9. Has the person to be vaccinated ever had Guillain-Barre' Syndrome? (a rare neurologic condition, usually temporary, that affects the nerves, causing muscle weakness and paralysis)	___ Yes   ___ No
10. Has the person to be vaccinated ever had a "pneumococcal vaccine" ie: <b>Pneumovax 23 or Prevnar 13 vaccine?</b>	___ Yes   ___ No
11. <b>For Females only:</b> Is the person to be vaccinated currently pregnant or planning to become pregnant within the next 28 days?	___ Yes   ___ No   ___ N/A

**Answer the following two questions ONLY IF: the person to be vaccinated is 18 years of age or younger!**

- 1.) How many people currently live in your home? \_\_\_\_\_  
 2.) What is your total household income? (optional)  
     Yearly\$ \_\_\_\_\_    Monthly\$ \_\_\_\_\_    Weekly\$ \_\_\_\_\_

### Client VFC Eligibility/Insurance Status:

Medicaid 19 \_\_\_\_\_ CHIP 21 \_\_\_\_\_ No Insurance \_\_\_\_\_ Under-Insured\* \_\_\_\_\_ American Indian/Alaskan Native \_\_\_\_\_ 317 \_\_\_\_\_ State \_\_\_\_\_ Private Insured \_\_\_\_\_  
\* Underinsured children: A child who has health insurance, but the coverage does not include vaccines or insurance covers only selected vaccines. The child is only eligible for vaccines not covered by the insurance plan.

I have been offered or provided, whether accepted or not, a copy of the "Vaccine Information Statement(s)" checked below. I have read, or have had explained to me, the information in the "Vaccine Information Statement(s)". My questions have been answered satisfactorily, and I ask that the vaccine(s) checked above are given to me or to the person named above for whom I am authorized to make this request by Marshall County Health Department. I acknowledge that I have received or been offered a copy of Marshall County Health Department's Notice of Privacy Practices with the revision date of February 28, 2016. As the client or parent/guardian, I understand I will be responsible to pay for any services provided that Medicaid, Medicare, KanCare or other private health insurance does not cover. I consent to inclusion of this immunization data in the Kansas Immunization Registry, and also consent to sharing of this immunization data with any licensed physician, the primary care provider, educational institutions and health insurance companies that request this information, on behalf of the person named above.

\_\_\_\_\_  
 Signature of Client or (parent if client is under 18yrs)      Printed Name of person signing      Social Security # of person signing      Date

Name \_\_\_\_\_

Age \_\_\_\_\_

DOB \_\_\_\_\_

## PROVIDER INFORMATION

Vaccine Provider: Marshall County Health Department  
600 Broadway  
Marysville, KS 66508  
785-562-3485

Clinic Site: \_\_\_\_\_

Street Address: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

KS

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

Vaccine	Dose	Ext	Site	Route	VIS Dates	Manufacturer & Lot #	Exp
DTaP/HepB/IPV	1 2 3	RT LT	Deltoid Vastus Lat	IM	Multi vaccine 11-5-15	GSK PFS	
DTaP/IPV	5 / 4	RT LT	Deltoid Vastus Lat	IM	8-24-18 7-20-16	GSK SDV	
DTaP, Td, Tdap	1 2 3 4 5 B	RT LT	Deltoid Vastus Lat	IM	8-24-18 4-11-17 2-24-15	SP, GSK PFS SDV	
HepA/HepB	1 2 3	RT LT	Deltoid Vastus Lat	IM	7-20-16	GSK PFS SDV	
Hep A	1 2	RT LT	Deltoid Vastus Lat	IM	7-20-16	GSK, Merck PFS SDV	
Hep B	1 2 3	RT LT	Deltoid Vastus Lat	IM	7-20-16	GSK PFS SDV	
Hib	1 2 3 4	RT LT	Deltoid Vastus Lat	IM	4-2-15 11-5-15	Merck, SP SDV	
HPV9	1 2 3	RT LT	Deltoid Vastus Lat	IM	12-2-16	Merck PFS SDV	
Influenza	1 2	RT LT	Deltoid Vastus Lat	IM	8-7-15	0.25ml 0.5ml -- MDV PFS SP	
Influenza High Dose	1	RT LT	Deltoid	IM	8-7-15	0.5ml --- PFS SP	
IPV	1 2 3 4	RT LT	Upper Arm Thigh	SQ	7-20-16	SP MDV	
Meningococcal (MCV4)	1 2 3	RT LT	Deltoid	IM	8-24-18	SP, GSK PFS SDV	
Meningococcal B	1 2	RT LT	Deltoid	IM	8-9-16	GSK PFS	
MMR	1 2 3	RT LT	Upper Arm Thigh	SQ	2-12-18	Merck SDV	
PCV13	1 2 3 4	RT LT	Deltoid Vastus Lat	IM	11-5-15	Wyeth/Pfizer PFS	
PPSV23	1 2	RT LT	Deltoid Upper Arm	IM	4-24-15	Merck SDV	
Rotavirus	1 2 3	-	PO	Oral	2-23-18	Merck, GSK	
Typhoid	1	RT LT	Deltoid Vastus Lat	IM	5-29-12	SP PFS	
Varicella	1 2	RT LT	Upper Arm Thigh	SQ	2-12-18	Merck SDV	
Zoster (RZV)	1 2	RT LT	Deltoid	IM	2-12-18	GSK SDV	

Signature and Title of Vaccine Administrator \_\_\_\_\_

Date \_\_\_\_\_

Return Visit Date \_\_\_\_\_

My initials indicate that the client and/or parent of the adolescent child was advised on a 10-15 minute, in clinic, post vaccination waiting period! Rev 8/18