VACCINE DOCUMENTATION AND CONSENT FORM

Rev.9/2020

☐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	ZIP

RACE	ETHNICITY	MARITAL STATUS	DOCTOR'S NAME:
White Black American Indian Asian	Hispanic or Non-Hispanic Mexican; Puerto Rican; South American	Married Divorced Single Widow	

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 *food, medication, vaccine or Latex* which produced a **life-threatening** reaction? **If yes, what item caused the allergy**:	____Yes ____No
3. Does the person to be vaccinated have a severely weakened immune system due to illness (ie: cancer, leukemia, or HIV) 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 a blood transfusion 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 medications that affect the immune system (ex: Methotrexate, Prednisone or other Steroid, Humira etc…)	____Yes ____No
6. Does the person to be vaccinated have any long term health problems: **autoimmune disorder (Lupus, Crohn's, RA), lung (asthma/wheezing/reactive airway), diabetes, heart, kidney, metabolic (Diabetes), liver disease, anemia, HIV, have a cochlear implant or have had spleen removed? (circle which applies)**	____Yes ____No
7. Does the person to be vaccinated have a history of seizures 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 (pneumonia) vaccine" ie: **Pneumovax 23 or Prevnar 13 vaccine?**	____Yes ____No
11. **For Females only**: 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.
317 is Federal funded program for uninsured (Flu season) *State is a State funded program ie (Cocoon Tdap)

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, TransactRx, 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: **KS**	Zip Code:

(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 4-1-2020	*PFS* GSK	
DTaP/IPV	5 / 4	RT LT	Deltoid Vastus Lat	IM	8-24-18 10-30-19	*PFS* GSK	
DTaP, Td, Tdap	1 2 3 4 5 **B**	RT LT	Deltoid Vastus Lat	IM	4-01-2020	*PFS, SDV* SP, GSK	
HepA/HepB	1 2 3	RT LT	Deltoid Vastus Lat	IM	7-20-16 8-15-19	*PFS* GSK	
Hep A	1 2	RT LT	Deltoid Vastus Lat	IM	7-28-2020	*PFS* GSK,Merck	
Hep B	1 2 3	RT LT	Deltoid Vastus Lat	IM	08-15-19	*PFS* GSK	
Hib	1 2 3 4	RT LT	Deltoid Vastus Lat	IM	10-30-19 4-1-2020	*SDV* Merck,SP	
HPV9	1 2 3	RT LT	Deltoid Vastus Lat	IM	10-30-19	*PFS* Merck	
Influenza Quad	1 2	RT LT	Deltoid Vastus Lat	IM	8-15-19	*0.5ml --- PFS* *Fluzone Fluaix. Flublok Flulaval*	**6-30-2021**
Influenza Quad High Dose	1	RT LT	Deltoid	IM	8-15-19	*0.7ml --- PFS* *Fluzone SP*	
IPV	1 2 3 4	RT LT	Upper Arm Thigh	SQ	10-30-19	*MDV* SP	
Meningococcal (MCV4)	1 2 3	RT LT	Deltoid	IM	8-15-19	*SDV* SP, GSK	
Meningococcal B	1 2	RT LT	Deltoid	IM	8-15-19	PFS GSK	
MMR	1 2 3	RT LT	Upper Arm Thigh	SQ	8-15-19	*SDV* Merck	
PCV13	1 2 3 4	RT LT	Deltoid Vastus Lat	IM	4-1-2020 10-30-19	*PFS* Wyeth/Pfizer	
PPSV23	1 2	RT LT	Deltoid	IM	10-30-19	*PFS* Merck	
Rotavirus	1 2 3	-	PO	Oral	10-30-19	Merck, GSK	
Typhoid	1	RT LT	Deltoid Vastus Lat	IM	10-30-19	SP *PFS*	
Varicella	1 2	RT LT	Upper Arm Thigh	SQ	8-15-19	*SDV* Merck	
Zoster (RZV)	1 2	RT LT	Deltoid	IM	10-30-19	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!**

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