

MCHD CLIENT REGISTRATION FORM

Adult responsible for payment

Name _____ Gender _____ Race _____ Ethnicity _____
(First) (MI) (Last)
Address _____ City _____ State _____ Zip _____

DOB _____ Main Phone # _____ SSN# _____

How do you want reminders sent: Text Automated Phone call Post Card

Marital Status: _____ Single _____ Married _____ Divorced _____ Separated _____ Widowed

Maiden Name: _____

Education Level Completed: _____ Less than 12 years of Primary School _____ HS Diploma _____ GED _____ College
Employment: _____ Full Time _____ Part Time _____ Seasonal _____ Unemployed _____ Retired 1yr, 2yr or 4yr

Listing of Children under the age of 18

| | | | | |
|-------|-----------|--------------|------------|-----------|
| _____ | DOB _____ | Gender _____ | Race _____ | Age _____ |
| _____ | DOB _____ | Gender _____ | Race _____ | Age _____ |
| _____ | DOB _____ | Gender _____ | Race _____ | Age _____ |
| _____ | DOB _____ | Gender _____ | Race _____ | Age _____ |
| _____ | DOB _____ | Gender _____ | Race _____ | Age _____ |
| _____ | DOB _____ | Gender _____ | Race _____ | Age _____ |

Please list below any person or agencies that we have your permission to release your medical information and the medical information of the above family members to, if requested.

HIPAA Waiver

Because the Marshall County Health Department is bound by the rules of the Health Insurance Portability and Accountability Act (HIPAA), we are unable to provide any information to any person other than you without your consent. This includes information about your account, your immunizations, health history, prescriptions and any other information contained in your medical records with us.

I acknowledge that I have received or have been offered a copy of the Marshall County Health Department's Notice of Privacy Practices with a revision date of February 28, 2016. I certify that the above information is correct to the best of my knowledge. I understand the Adult listed above will be responsible for any services provided in which the insurance does not cover.

IF WE ARE FILING INSURANCE:

Insured or authorized person's signature: I authorize payment of medical benefits to Marshall County Health Department. I also authorize the release of any medical or other personal information necessary to process this claim.

How many people currently reside in your home? _____

What is your family income (pick one)? (yearly) _____ (monthly) _____ (weekly) _____

Email address: _____

Authorized Signature _____ Date _____

VACCINE DOCUMENTATION AND CONSENT FORM

(Rev. 6/2026)

- DTaP Hep A Hep B HIB HPV Influenza (Flu) IPV MCV4 Men B
MMR PCV Rotavirus RSV Tdap Typhoid Varicella Zoster COVID

| | | | | | |
|---|--|--|-------|---|---------------------------------|
| NAME (Last) | | (First) | | (M.I.) | |
| BIRTHDAY (DOB) | | AGE | PHONE | TEXT | REMINDER: CALL POSTCARD |
| ADDRESS | | | CITY | STATE | ZIP |
| RACE White Black American Indian Asian | | ETHNICITY Hispanic or Non-Hispanic Mexican; Puerto Rican; South American | | MARITAL STATUS Single Married Divorced Widowed | |
| | | | | GENDER Male Female | |

| 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, vaccine or Latex</u> which produced a life-threatening reaction? If yes, please list 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? | ___ 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, Prevnar 13,15 or Prevnar 20 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 |
| 12. Has the person to be vaccinated tested positive with COVID disease in the previous 3 months? (if yes, consider delaying COVID vaccine for 3 months from illness onset) | ___ Yes ___ No |

Client VFC Eligibility/Insurance Status:

Medicaid 19 CHIP 21 No Insurance Under-Insured* American Indian/Alaskan Native 317† State†† Private Insured

* Under-insured 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 or underinsured adults/Bridge Access Program ††State is a State funded program for uninsured and underinsured adults and special projects 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.

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

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

NAME _____

DOB _____

(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 7-24-23 | GSK <i>PFS</i> | |
| DTaP-IPV | 5 / 4 | RT LT | Deltoid Vastus Lat | IM | 8-6-21 1-31-25 | GSK <i>PFS</i> | |
| DTaP, Td, Tdap | 1 2 3 4 5 B | RT LT | Deltoid Vastus Lat | IM | 8-6-21 1-31-25 | SP, GSK <i>PFS, SDV</i> | |
| HepA-HepB | 1 2 3 | RT LT | Deltoid Vastus Lat | IM | 1-31-25 | GSK <i>PFS</i> | |
| Hep A (Ped) (Adult) | 1 2 | RT LT | Deltoid Vastus Lat | IM | 1-31-25 | GSK <i>PFS</i> | |
| Hep B (Ped) (Adult) | 1 2 3 | RT LT | Deltoid Vastus Lat | IM | 1-31-25 | GSK <i>PFS, SDV</i> | |
| Hib | 1 2 3 4 | RT LT | Deltoid Vastus Lat | IM | Multi 7-24-23 8-6-21 | Merck <i>SDV</i> | |
| HPV9 | 1 2 3 | RT LT | Deltoid Vastus Lat | IM | 8-6-21 | Merck <i>PFS</i> | |
| Influenza TIV | 1 2 | RT LT | Deltoid Vastus Lat | IM | 1-31-25 | 0.5ml --- <i>PFS</i> <i>Fluarix, Flublok Flulaval, Fluzone</i> | 6-30-2027 |
| Influenza TIV High Dose | 1 | RT LT | Deltoid | IM | 1-31-25 | 0.7ml --- <i>PFS</i> <i>Fluzone/SP</i> | |
| IPV | 1 2 3 4 | RT LT | Upper Arm Thigh | SQ | 1-31-25 | SP <i>MDV</i> | |
| Meningococcal (MCV4) | 1 2 3 | RT LT | Deltoid | IM | 1-31-25 | SP, GSK <i>SDV</i> | |
| MCV4 – Men B | 1 2 1 2 | RT LT | Deltoid | IM | 1-31-25 | GSK <i>PFS</i> | |
| Meningococcal B | 1 2 | RT LT | Deltoid | IM | 1-31-25 | GSK <i>PFS</i> | |
| MMR | 1 2 3 | RT LT | Upper Arm Thigh | SQ | 1-31-25 | Merck <i>SDV</i> | |
| PCV 20 | 1 2 3 4 | RT LT | Deltoid Vastus Lat | IM | Multi 7-24-23 5-29-25 | Wyeth/Pfizer <i>PFS</i> | |
| RSV- RSV Antibody | 1 | RT LT | Deltoid Vastus Lat | IM | 1-31-25 9-25-23 | GSK, SP 50mg / 100mg <i>PFS, SDV</i> | |
| Rotavirus | 1 2 3 | - | PO | Oral | 10-15-21 | GSK | |
| Typhoid | 1 | RT LT | Deltoid Vastus Lat | IM | 10-30-19 | SP <i>PFS</i> | |
| Varicella | 1 2 | RT LT | Upper Arm Thigh | SQ | 1-31-25 | Merck <i>SDV</i> | |
| Zoster (RZV) | 1 2 | RT LT | Deltoid | IM | 2-4-22 | GSK <i>PFS</i> | |
| COVID (6m-11y) (12y+) | 1 2 | RT LT | Deltoid | IM | 1-31-25 | Moderna <i>PFS</i> | |

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! 6/2026