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**_____

Rev 2/25 CS

VACCINE DOCUMENTATION AND CONSENT FORM

Rev. 9/2025

☐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**	**REMINDER:** TEXT 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 *food, medication, vaccine or Latex* 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 or illness risk factors: **autoimmune disorder (Lupus, Crohn's, RA), lung (asthma/wheezing/reactive airway/COPD), diabetes, heart, kidney, metabolic (Diabetes), liver disease, anemia, HIV, obesity, cigarette/vape smoker, alcohol misuse, 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_____

** 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 and underinsured adults/Bridge Access Program *State is a State funded special program for adults*

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 18yrs)	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	*PFS* GSK	
DTaP/IPV	5 / 4	RT LT	Deltoid Vastus Lat	IM	8-6-21 1-31-25	*PFS* GSK	
DTaP, Td, Tdap	1 2 3 4 5 **B**	RT LT	Deltoid Vastus Lat	IM	8-6-21 1-31-25	*PFS* SP, GSK	
HepA/HepB	1 2 3	RT LT	Deltoid Vastus Lat	IM	1-31-25	*PFS* GSK	
Hep A	1 2	RT LT	Deltoid Vastus Lat	IM	1-31-25	*PFS* GSK,Merck	
Hep B	1 2 3	RT LT	Deltoid Vastus Lat	IM	1-31-25	*PFS* GSK	
Hib	1 2 3 4	RT LT	Deltoid Vastus Lat	IM	Multi 7-24-23 8-6-21	*SDV* Merck,SP	
HPV9	1 2 3	RT LT	Deltoid Vastus Lat	IM	8-6-21	*PFS* Merck	
Influenza TIV	1 2	RT LT	Deltoid Vastus Lat	IM	1-31-25	*0.5ml --- PFS* *Fluarix, Flublok , Fluzone*	**6-30-26**
Influenza TIV High Dose	1	RT LT	Deltoid	IM	1-31-25	*0.7ml --- PFS* *Fluzone/SP*	**6-30-26**
IPV	1 2 3 4	RT LT	Upper Arm Thigh	SQ	1-31-25	*MDV* SP	
Meningococcal (MCV4)	1 2 3	RT LT	Deltoid	IM	1-31-25	*SDV* GSK-Menveo	
Meningococcal B	1 2	RT LT	Deltoid	IM	1-31-25	PFS GSK	
MMR	1 2 3	RT LT	Upper Arm Thigh	SQ	1-31-25	*SDV* Merck	
PCV 20	1 2 3 4	RT LT	Deltoid Vastus Lat	IM	Multi 7-24-23 5-29-25	*PFS* Wyeth/Pfizer	
RSV	1	RT LT	Deltoid Vastus Lat	IM	1-31-25	PFS SDV GSK, Sanofi, Pfizer	
Rotavirus	1 2 3	-	PO	Oral	10-15-21	PO Merck, GSK	
Typhoid	1	RT LT	Deltoid Vastus Lat	IM	10-30-19	SP *PFS*	
Varicella	1 2	RT LT	Upper Arm Thigh	SQ	1-31-25	*SDV* Merck	
Zoster (RZV)	1 2	RT LT	Deltoid	IM	2-4-22	GSK *SDV*	
COVID	**1** **2**	RT LT	Deltoid Vastus Lat	IM	1-31-25	Moderna PFS 0.25ml (6m-11y) 0.5ml (12+)	

_____ _____ _____

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! 9-2025**