

## 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 asked that the vaccine(s) checked below be given to me or to the person named below for whom I am 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.

- Influenza-inactivated (shot)                       Pneumococcal (PPSV23)  
 Pneumococcal (PCV13)                               Tdap  
 Zoster

- I hereby authorize the release of my immunization records to appropriate healthcare providers.  
 **Medicare Eligible Clients:** I give permission to the Hodgeman County Health Department to bill Medicare for the vaccine(s) checked above.

\_\_\_\_\_  
Signature of Patient or Parent/Guardian

\_\_\_\_\_  
Date

Patient Information					
Patients Last Name	Patients First Name	Phone #	Age	Birth Date	Gender M      F
Street Address / PO Box #		City	County	State	Zip
Parent/Guardian:			Birth Date:		
Primary Care Physician:					

### Immunization Screening Questionnaire

1. Does the patient have allergies to medications, food, a vaccine component, or latex (ex. eggs, gentamicin, gelatin, or thimerosal)?	___yes    ___no
2. Has the patient had a serious reaction to a vaccine in the past?	___yes    ___no
3. Has the person to be vaccinated ever had Guillain-Barré Syndrome?	___yes    ___no
4. Is the patient to be vaccinated currently sick or experiencing a high fever?	___yes    ___no
5. Have you had? Pneumonia vaccine ___Yes/___No    Zoster vaccine(Shingles) ___Yes/___No    Tdap vaccine ___Yes/___No	
6. Has the patient had a health problem with lung, heart, kidney or metabolic disease (e.g. diabetes), asthma, seizures, nervous system problem or blood disorder? Is he/she on long-term aspirin therapy?	___yes    ___no
7. Does the person to be vaccinated have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as steroids, or cancer treatment with x-rays or drugs?	___yes    ___no
8. 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
9. For women only: Is the person to be vaccinated pregnant or could she become pregnant within the next month?	___yes    ___no
10. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in a protective environment (such as in a hospital isolation room)?	___yes    ___no
11. Has the person to be vaccinated received any other vaccinations in the last 4 weeks?	___yes    ___no

#### PATIENT ELIGIBILITY

KanCare     Underinsured     Underserved     No Health insurance     Native AM/Alaska Native     Fully Insured     Medicare  
 T19/T21

Name, as it appears on Medicare Card \_\_\_\_\_

Medicare Number \_\_\_\_\_

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

For Clinical Use Only						
VACCINE	EXT	SITE	ROUTE	VIS DATE	MANUFACTURER LOT #	EXP DATE
<b>Influenza, Inactivated</b>	<b>0.1ml 0.25ml 0.5ml</b> RT LT	<b>Deltoid Vastus Lat Upper Arm</b>	<b>IM</b> Intradermal	<b>08-07-15</b>		
<b>PPSV23</b>	RT LT	<b>Deltoid</b>	<b>IM</b>	04-24-15		
<b>PCV13</b>				11-05-15		
<b>Tdap</b>	RT LT	<b>Upper Arm</b>	<b>SC</b>	02-24-15		
<b>Zoster</b>				10-06-09		

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

\_\_\_\_\_  
Date

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

For Clinical Use Only						
VACCINE	EXT	SITE	ROUTE	VIS DATE	MANUFACTURER LOT #	EXP DATE
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\_\_\_\_\_  
Signature and Title of Vaccine Administrator

\_\_\_\_\_  
Date

**Date** \_\_\_\_\_ **Progress Notes** \_\_\_\_\_

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Provider Information
Hodgeman County Health Department c/o Courthouse, 500 Main PO Box 86 Jetmore, KS 67854 (620) 357-8736