MULTI-VACCINE DOCUMENTATION/CONSENT FORM

I have been offered a copy of the "Vaccine Information Statement"(VIS) checked below. I have read, have had explained to me, and understand the information in the "Vaccine Information Statements"(VIS)s. I ask that the vaccine(s) checked below be given to me or to the person named 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.

□ Hep A (2 doses) □ Hep B (3 doses) □ Tdap (1 dose) □ HPV (3 doses) □ MCV4 (1 dose)

□ Varicella (1 dose or 2 doses) □ MenB □ Other_____

□ I consent for the vaccines checked above to be given to my child at school.

_____ _____

Signature of Patient or Parent/Guardian Date

(After giving consent, if you change your mind and do not want to complete the series, please call the Health Department at 620-357-8736)

Patient Information				
Patient's Last Name Patient's First Name	Phone #	Age	Date of Birth	
Street Name/Po Box #	City	County	State	Zip
Ethnicity: Hispanic or Latino _____Yes _____No **Gender** _____Male _____Female	**Race**: (Select one or more) ___AS-Asian/Pacific Islander/Other ___HA-Hawaiian ___BL-Black or African American ___IN-American Indian/Alaska Native ___CA-Caucasian/Mexican/Puerto Rican ___JA-Japanese ___CH-Chinese ___NW-Other Non-White ___FI-Filipino ___UN-Unknown			
Primary Care Physician:	Street Address: City:	State: Zip:	Phone: Fax:	
PATIENT ELIGIBILITY				
___KanCare(T19/T21) ___No Health Insurance ___American Indian/Alaska Native ___Underinsured ___Fully Insured				

Immunization Screening Questionnaire	
1. Is the person to be vaccinated currently sick or experiencing a high fever?	___Yes ___No
2. Has the person to be vaccinated had a serious reaction to a vaccine in the past?	___Yes ___No
3. Does the person to be vaccinated have any allergies that produce a severe (anaphylactic) reaction?	___Yes ___No
4. Has the person to be vaccinated had a seizure or other neurological problems?	___Yes ___No
5. Does the person to be vaccinated have any medical problems that make it hard for him/her to fight infection?	___Yes ___No
6. Is the person to be vaccinated currently taking cortisone, prednisone, other steroids, or anti-cancer drugs, or x-ray treatments?	___Yes ___No
7. Has the person to be vaccinated received blood, plasma, or immune globulin in the past 12 months?	___Yes ___No
8. Is the person to be vaccinated pregnant or thinking of becoming pregnant within the next three months?	___Yes ___No

Provider: Hodgeman County Health Department: 500 Main/Po Box 86 Jetmore, KS 67854 (620) 357-8736

For Clinic Use Only

DOSE #1 (Circle the appropriate vaccine, dose, extremity, site, route, and enter the VIS date, manufacturer, lot #, and expiration date)

Vaccine	Dose	Ext	Site	Route	VIS Date	Manufacturer Lot#	Exp Date
Hep A Hep B			Deltoid	IM			
Tdap HPV			Deltoid	IM			
MCV4 MenB			Deltoid	IM			
Varicella			Upper Arm	SQ			

Signature and Title of Vaccine Administrator _____ Date _____

DOSE #2 (Circle the appropriate vaccine, dose, extremity, site, route, and enter the VIS date, manufacturer, lot #, and expiration date)

Vaccine	Dose	Ext	Site	Route	VIS Date	Manufacturer Lot#	Exp Date
Hep A Hep B			Deltoid	IM			
Tdap HPV			Deltoid	IM			
MCV4 MenB			Upper Arm	SQ			
Varicella							

Signature and Title of Vaccine Administrator _____ Date _____

DOSE #3 (Circle the appropriate vaccine, dose, extremity, site, route, and enter the VIS date, manufacturer, lot #, and expiration date)

Vaccine	Dose	Ext	Site	Route	VIS Date	Manufacturer Lot#	Exp Date
Hep A Hep B			Deltoid	IM			
Tdap HPV			Deltoid	IM			
MCV4 MenB			Upper Arm	SQ			
Varicella							

Signature and Title of Vaccine Administrator _____ Date _____

DOSE #4 (Circle the appropriate vaccine, dose, extremity, site, route, and enter the VIS date, manufacturer, lot #, and expiration date)

Vaccine	Dose	Ext	Site	Route	VIS Date	Manufacturer Lot#	Exp Date
			Deltoid	IM			
			Deltoid	IM			
			Upper Arm	SQ			

Signature and Title of Vaccine Administrator _____ Date _____