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
Influenza, Inactivated	**0.1ml 0.25ml 0.5ml RT LT**	**Deltoid Vastus Lat Upper Arm**	IM Intradermal	08-07-15		
PPSV23	RT LT	**Deltoid**	IM	04-24-15		
PCV13				11-05-15		
Tdap	RT LT	**Upper Arm**	**SC**	02-24-15		
Zoster				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
Influenza, Inactivated	0.1ml 0.25ml 0.5ml RT LT	**Deltoid Vastus Lat Upper Arm**	IM Intradermal	08-07-15		

_____ _____

Signature and Title of Vaccine Administrator Date

Date **Progress Notes** _____

_____

_____

_____

Provider Information

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