MULTI-VACCINE DOCUMENTATION / CONSENT FORM

I have been offered a copy of the Vaccine Information Statements (VIS) checked below. I have read, have had explained to me, and understand the information in the Vaccine Information Statements (VIS). I ask 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 the behalf of the person named below.
I consent for the vaccines checked below to be given to my child at school.

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

□ Varicella (1 dose or 2 doses) □ MenB (2 doses) □ Other _____

_____ _____
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 Dept at 620-357-8736.)

Patient Information				
Patient's Last Name Patient's First Name	Phone #	Age	Birth Date	
Street Address / 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 19 or 21 ___ No Health Insurance ___Native AM/Alaska Native ___Underinsured* ___Underserved** ___Insured

*Underinsured children: insurance does not cover vaccines. Eligible in VFC program if vaccinated at a FQHC, RHC or delegated LHD.
**Underserved children: (Are not VFC eligible) May only be vaccinated with KIP vaccines needed at school entry (K-12) at a LHD if enrolled in federal free or reduced school lunch program.

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 problem?	___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 twelve 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; Courthouse, 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			Deltoid	IM			
Hep B							
HPV			Deltoid	IM			
Tdap							
MCV4			Deltoid	IM			
MenB							
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			Deltoid	IM			
Hep B							
HPV			Deltoid	IM			
Tdap							
MCV4							
MenB							
Varicella			Upper Arm	SQ			

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			Deltoid	IM			
Hep B							
HPV			Deltoid	IM			
Tdap							
MCV4							
MenB							
Varicella			Upper Arm	SQ			

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