VACCINE DOCUMENTATION AND CONSENT FORM

Rev.1/2017

☐DTaP ☐Hep A ☐Hep B ☐HIB ☐HPV ☐Influenza (Flu) ☐IPV ☐MCV4 ☐Men B
☐MMR ☐PCV13 ☐PPSV23 ☐Rotavirus ☐Td ☐Tdap ☐ Typhoid ☐Varicella ☐Zostavax

NAME (Last)	(First)	(M.I.)

BIRTHDAY (DOB)	AGE	GENDER M / F	PHONE

ADDRESS	CITY	STATE	ZIP

RACE	ETHNICITY	MARITAL STATUS	DOCTOR'S NAME:
White Black American Indian Asian	Hispanic Non-Hispanic	Married Divorced Single Widow	

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 or vaccine* that produced a **life-threatening** reaction? If yes, what:	___Yes ___No
3. Does the person to be vaccinated have a severely weakened immune system due to illness 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 blood products 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 immune suppressing &/or antiviral medicines in the past seven days? (ex: Methotrexate, Prednisone, Tamiflu, Valtrex, Zovirax) **or For Children and Teens**: Do they take a daily aspirin?	___Yes ___No
6. Does the person to be vaccinated have any long term health problems: **autoimmune disorder (lupus, RA), lung (asthma/wheezing/reactive airway), diabetes, heart, kidney, liver disease, anemia, HIV? (circle which applies)**	___Yes ___No
7. Does the person to be vaccinated have a history of convulsions 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? If yes, what:	___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 vaccine" ie: **Pneumovax 23 or Prevnar 13 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

Answer the following two questions ONLY IF: the person to be vaccinated is 18 years of age or younger!

1.) How many people currently live in your home? _____

2.) What is your total household income? **(optional)**

Yearly$ _____ Monthly$ _____ Weekly$ _____

Client VFC Eligibility/Insurance Status:

Medicaid 19_____ CHIP 21_____ No Insurance _____ Under-Insured*_____ American Indian/Alaskan Native_____ 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.

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, 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.

Signature of Client *or* (parent if client is under 18yrs)	Printed Name of person signing	Social Security # of person signing	Date

Name _____ Age _____ DOB _____

PROVIDER INFORMATION			
Vaccine Provider: Marshall County Health Department 600 Broadway Marysville, KS 66508 785-562-3485	Clinic Site:		
	Street Address:	State: **KS**	Zip Code:

(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 11-5-15	*PFS* GSK	
DTaP/IPV	5 / 4	RT LT	Deltoid Vastus Lat	IM	5-17-07 7-20-16	*SDV* GSK	
DTaP, Td, Tdap	1 2 3 4 5 **B**	RT LT	Deltoid Vastus Lat	IM	5-17-07 2-24-15	*PFS SDV* SP, GSK	
HepA/HepB	1 2 3	RT LT	Deltoid Vastus Lat	IM	7-20-16	*PFS SDV* GSK	
Hep A	1 2	RT LT	Deltoid Vastus Lat	IM	7-20-16	*PFS SDV* GSK,Merck	
Hep B	1 2 3	RT LT	Deltoid Vastus Lat	IM	7-20-16	*PFS SDV* GSK	
Hib	1 2 3 4	RT LT	Deltoid Vastus Lat	IM	4-2-15 11-5-15	*SDV* Merck,SP	
HPV9	1 2 3	RT LT	Deltoid Vastus Lat	IM	12-2-16	*SDV* Merck	
Influenza	1 2	RT LT	Deltoid Vastus Lat	IM	8-7-15	*0.25ml 0.5ml -- MDV PFS* SP	**6-30-17**
Influenza (Flu-mist)	1 2	-	Nasal	Intranasal		**MedImmune** SPRAYER	
IPV	1 2 3 4	RT LT	Upper Arm Thigh	SQ	7-20-16	*MDV* SP	
Meningococcal (MCV4) OR Meningococcal B	1 2 3	RT LT	Deltoid	IM	3-31-16 8-9-16	*PFS SDV* SP, Novartis, GSK	
MMR	1 2	RT LT	Upper Arm Thigh	SQ	4-20-12	*SDV* Merck	
PCV13	1 2 3 4	RT LT	Deltoid Vastus Lat	IM	11-5-15	*PFS* Wyeth/Pfizer	
PPSV23	1 2	RT LT	Deltoid Upper Arm	IM	4-24-15	*SDV* Merck	
Rotavirus	1 2 3	-	PO	Oral	4-15-15	Merck, GSK	
Typhoid	1	LT RT	Deltoid Vastus Lat	IM	5-29-12	SP *PFS*	
Varicella	1 2	RT LT	Upper Arm Thigh	SQ	3-13-2008	*SDV* Merck	
Zoster	1	RT LT	Upper Arm	SQ	10-06-2009	Merck *SDV*	

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 15 minute, in clinic, post vaccination waiting period.**