

Kansas Department of Health and Environment Vaccine Documentation and Consent Form

I have been offered a copy of the Vaccine Information Statement(s) (VIS) or Emergency Use Authorization (EUA) fact sheet(s) checked below. I have read, had explained to me, and understand the information in the VIS(s)/fact sheet(s). 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 Information System for myself or on behalf of the person named below.

- COVID-19
 DTaP
 DTaP-IPV
 DTaP-IPV/Hib
 DTaP-IPV-Hib-Hep B
 Hep A
 Hep B
 Hib
 HPV
 Influenza
 MenACWY
 MenB
 MMR
 MMRV
 PCV 20
 Polio/IPV
 Rotavirus
 RSV
 Td
 Tdap
 Varicella
 Other _____
Adult only – Hep A-Hep B (TwinRix)
 Shingles

Patient Information											
Patient's Last Name:			Patient's First Name:			Phone Number:		Age:		Birth Date:	
Street Address:				City:		County:		State:		Zip Code:	
Email Address:			Gender: <input type="checkbox"/> Male (including transgender men) <input type="checkbox"/> Female (including transgender women) <input type="checkbox"/> Prefer to self-describe as _____ (Non-binary, gender-fluid, agender, please specify) <input type="checkbox"/> Prefer not to say Do you identify as transgender or have a transgender history? <input type="checkbox"/> Yes <input type="checkbox"/> No			Race: (Select one or more.) <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Other Non-White <input type="checkbox"/> Unknown					
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Hispanic or Latino–Central/South American <input type="checkbox"/> Hispanic or Latino–Cuban <input type="checkbox"/> Hispanic or Latino–Mexican <input type="checkbox"/> Hispanic or Latino–Puerto Rican <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			Street Address:			State:		Phone Number:		Zip Code:	
PATIENT ELIGIBILITY											
<input type="checkbox"/> T19-MED	<input type="checkbox"/> T21-SCHIP	<input type="checkbox"/> Uninsured*	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> 317	<input type="checkbox"/> Underinsured*	<input type="checkbox"/> State	<input type="checkbox"/> Fully Insured (Not VFC Eligible)	<input type="checkbox"/> Medicare			

*Underinsured: insurance does not cover immunizations. Adults are eligible for certain immunizations through the Bridge or VFA program. Underinsured children are eligible for all ACIP recommended immunizations through the VFC Program, if vaccinated at a FQHC, RHC, or deputized county health department.

Immunization Screening Questionnaire	
For patients: The following questions will help determine which vaccines you may be given today. Answering "yes" to any question, does not necessarily mean you should not be vaccinated. It means we may need to ask more questions. If you are unsure of the answer, please ask your health care provider to explain.	
1. Is the patient to be vaccinated currently sick or experiencing a high fever?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
2. Does the patient have allergies to medications, food, a vaccine component, or latex?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
3. Has the patient had a serious reaction to a vaccine in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
4. Has the patient had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Is the patient on long-term aspirin therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
5. If the patient to be vaccinated is between the ages of 2 and 4 years, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> NA
6. If the patient is a baby, have you ever been told that the patient has had intussusceptions?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> NA
7. Has the patient, a sibling, or a parent had a seizure; had brain or other nervous system problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
8. Does the patient have cancer, leukemia, HIV/AIDS, or any other immunocompromising condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
9. Does the patient have a parent, brother, or sister with an immune system problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
10. In the past 3 months, has the patient taken medications that weaken the immune system such as cortisone, prednisone, other steroids, or anticancer drugs, drugs for the treatment of rheumatoid arthritis, Crohn's disease, psoriasis, or had radiation treatments?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
11. 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
12. Is the patient pregnant or is there a chance of becoming pregnant during the next month?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> NA
13. Has the patient received vaccinations in the past 4 weeks? If yes:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
*Healthcare Professionals: For assistance with interpreting the answers to the screening questionnaire for children and teens, refer to Immunize.Org/catg.d/p4060.pdf . For adults, refer to Immunize.Org/catg.d/p4065.pdf .	

Signature of Patient or Parent/ Guardian

Date

Street Address: 201 S Main State:KS Zip Code: 66087 Fax: 785-985-3550

(Mark the appropriate vaccine, dose, extremity, site, route, enter the manufacturer, lot #, expiration date, VIS or EUA Fact Sheet date.)

For Clinical Use Only

VACCINE	DOSE	EXT	SITE	ROUTE	VIS/EUA REV DATE	MANUFACTURER LOT NUMBER	EXP DATE
<input type="checkbox"/> COVID-19	<input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Deltoid <input type="checkbox"/> Vastus Lat	<input type="checkbox"/> IM	10/19/23		
<input type="checkbox"/> DTaP	0.5 mL <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Deltoid <input type="checkbox"/> Vastus Lat	<input type="checkbox"/> IM	8/6/21		
<input type="checkbox"/> DTaP/IPV	0.5 mL <input type="checkbox"/> 5 th DTaP—4 th IPV	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Deltoid <input type="checkbox"/> Vastus Lat	<input type="checkbox"/> IM	8/6/21		
<input type="checkbox"/> DTaP-IPV-Hib-Hep B	0.5 mL <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Deltoid <input type="checkbox"/> Vastus Lat	<input type="checkbox"/> IM	7/4/23		
<input type="checkbox"/> DTaP/Hib/IPV	0.5 mL <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Deltoid <input type="checkbox"/> Vastus Lat	<input type="checkbox"/> IM	8/6/21		
<input type="checkbox"/> Hep A	<input type="checkbox"/> 0.5 mL <input type="checkbox"/> 1.0 mL <input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Deltoid <input type="checkbox"/> Vastus Lat	<input type="checkbox"/> IM	10/15/21		
<input type="checkbox"/> Hep B	<input type="checkbox"/> 0.5 mL <input type="checkbox"/> 1.0 mL <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Deltoid <input type="checkbox"/> Vastus Lat	<input type="checkbox"/> IM	5/12/23		
<input type="checkbox"/> Hep A & Hep B	<input type="checkbox"/> 0.5 mL <input type="checkbox"/> 1.0 mL <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Deltoid <input type="checkbox"/> Vastus Lat	<input type="checkbox"/> IM	10/15/21, 5/12/23		
<input type="checkbox"/> Hib	0.5 mL <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Deltoid <input type="checkbox"/> Vastus Lat	<input type="checkbox"/> IM	8/6/21		
<input type="checkbox"/> HPV	0.5 mL <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Deltoid	<input type="checkbox"/> IM	8/6/21		
<input type="checkbox"/> Influenza	<input type="checkbox"/> 0.20 mL <input type="checkbox"/> 0.50 mL <input type="checkbox"/> 0.70 mL <input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Intranasal <input type="checkbox"/> Deltoid <input type="checkbox"/> Vastus Lat	<input type="checkbox"/> Intranasal <input type="checkbox"/> IM	8/6/21		
<input type="checkbox"/> MenACWY	0.5 mL <input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Deltoid	<input type="checkbox"/> IM	8/6/21		
<input type="checkbox"/> MENB	0.5 mL <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Deltoid	<input type="checkbox"/> IM	8/6/21		
<input type="checkbox"/> MMR	0.5 mL <input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Upper Arm <input type="checkbox"/> Thigh <input type="checkbox"/> Deltoid <input type="checkbox"/> Vastus Lat	<input type="checkbox"/> SC <input type="checkbox"/> IM	8/6/21		
<input type="checkbox"/> MMRV	0.5 mL <input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Upper Arm <input type="checkbox"/> Thigh <input type="checkbox"/> Deltoid <input type="checkbox"/> Vastus Lat	<input type="checkbox"/> SC <input type="checkbox"/> IM	8/6/21		
<input type="checkbox"/> PCV 20	0.5 mL <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Deltoid <input type="checkbox"/> Vastus Lat	<input type="checkbox"/> IM	5/12/23 7/4/23		
<input type="checkbox"/> Polio/IPV	0.5 mL <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Deltoid <input type="checkbox"/> Upper Arm <input type="checkbox"/> Thigh	<input type="checkbox"/> IM <input type="checkbox"/> SC	8/6/21 7/24/23		
<input type="checkbox"/> Rotavirus	2.0 mL <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<input type="checkbox"/> By Mouth	<input type="checkbox"/> Oral	10/15/21		
<input type="checkbox"/> RSV	Adult <input type="checkbox"/> 0.5 mL <input type="checkbox"/> 1	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Deltoid <input type="checkbox"/> Vastus Lat	<input type="checkbox"/> IM	10/19/23		
<input type="checkbox"/> Shingles	0.5 mL <input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Deltoid	<input type="checkbox"/> IM	2/4/22		
<input type="checkbox"/> Tdap <input type="checkbox"/> Td	0.5 mL Series # __	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Deltoid	<input type="checkbox"/> IM	8/6/21		
<input type="checkbox"/> Varicella	0.5 mL <input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Upper Arm <input type="checkbox"/> Deltoid <input type="checkbox"/> Vastus Lat	<input type="checkbox"/> IM <input type="checkbox"/> SQ	8/6/21		

Signature and Title of Vaccine Administrator

Date