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: **Ethnicity:** ☐Hispanic or Latino ☐Hispanic or Latino–Central/South American ☐Hispanic or Latino–Cuban ☐Hispanic or Latino–Mexican ☐Hispanic or Latino–Puerto Rican ☐Not Hispanic or Latino ☐Unknown	**Gender:** ☐Male (including transgender men) ☐Female (including transgender women) ☐ Prefer to self-describe as _____ (Non-binary, gender-fluid, agender, please specify) ☐Prefer not to say Do you identify as transgender or have a transgender history? ☐Yes ☐No	**Race:** (Select one or more.) ☐American Indian/Alaskan Native ☐Asian ☐Black or African American ☐Caucasian/White ☐Native Hawaiian or Other Pacific Islander ☐Other Non-White ☐Unknown

Primary Care Physician:	**Street Address:** **City:**	**State:** **Zip Code:**	**Phone Number:**

PATIENT ELIGIBILITY								
☐T19-MED	☐T21-SCHIP	☐Uninsured*	☐American Indian/Alaska Native	☐317	☐Underinsured*	☐State	☐Fully Insured (Not VFC Eligible)	☐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?	☐Yes ☐No ☐Don't know
2. Does the patient have allergies to medications, food, a vaccine component, or latex?	☐Yes ☐No ☐Don't know
3. Has the patient had a serious reaction to a vaccine in the past?	☐Yes ☐No ☐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?	☐Yes ☐No ☐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?	☐Yes ☐No ☐Don't know ☐NA
6. If the patient is a baby, have you ever been told that the patient has had intussusceptions?	☐Yes ☐No ☐Don't know ☐NA
7. Has the patient, a sibling, or a parent had a seizure; had brain or other nervous system problems?	☐Yes ☐No ☐Don't know
8. Does the patient have cancer, leukemia, HIV/AIDS, or any other immunocompromising condition?	☐Yes ☐No ☐Don't know
9. Does the patient have a parent, brother, or sister with an immune system problem?	☐Yes ☐No ☐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?	☐Yes ☐No ☐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?	☐Yes ☐No ☐Don't know
12. Is the patient pregnant or is there a chance of becoming pregnant during the next month?	☐Yes ☐No ☐Don't know ☐NA
13. Has the patient received vaccinations in the past 4 weeks? If yes:	☐Yes ☐No ☐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

Vaccine Provider: Doniphan County Health Department/HH			
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
☐COVID-19	☐ ☐1 ☐2	☐R ☐L	☐Deltoid ☐Vastus Lat	☐IM			
☐DTaP	0.5 mL ☐1 ☐2 ☐3 ☐4 ☐5 ☐6	☐R ☐L	☐Deltoid ☐Vastus Lat	☐IM			
☐DTaP/IPV	0.5 mL ☐5th DTaP—4th IPV	☐R ☐L	☐Deltoid ☐Vastus Lat	☐IM			
☐DTaP-IPV-Hib-Hep B	0.5 mL ☐1 ☐ 2 ☐3	☐R ☐L	☐Deltoid ☐Vastus Lat	☐IM			
☐DTaP/Hib/IPV	0.5 mL ☐1☐ 2☐ 3☐ 4	☐R ☐L	☐Deltoid ☐Vastus Lat	☐IM			
☐Hep A	☐0.5 mL ☐1.0 mL ☐1 ☐2	☐R ☐L	☐Deltoid ☐Vastus Lat	☐IM			
☐Hep B	☐0.5 mL ☐1.0 mL ☐1 ☐2 ☐3	☐R ☐L	☐Deltoid ☐Vastus Lat	☐IM			
☐ Hep A & Hep B	☐0.5 mL ☐1.0 mL ☐1 ☐2 ☐3	☐R ☐L	☐Deltoid ☐Vastus Lat	☐IM			
☐Hib	0.5 mL ☐1☐ 2☐ 3☐ 4	☐R ☐L	☐Deltoid ☐Vastus Lat	☐IM			
☐HPV	0.5 mL ☐1 ☐ 2 ☐3	☐R ☐L	☐Deltoid	☐IM			
☐Influenza	☐ 0.20 mL ☐ 0.50 mL ☐ 0.70 mL ☐1 ☐ 2	☐R ☐L	☐Intranasal ☐Deltoid ☐Vastus Lat	☐Intranasal ☐IM			
☐MenACWY	0.5 mL ☐1 ☐ 2	☐R ☐L	☐Deltoid	☐IM			
☐MENB	0.5 mL ☐1 ☐ 2 ☐3	☐R ☐L	☐Deltoid	☐IM			
☐MMR	0.5 mL ☐1 ☐ 2	☐R ☐L	☐Upper Arm ☐Thigh ☐Deltoid ☐Vastus Lat	☐SC ☐IM			
☐MMRV	0.5 mL ☐1 ☐ 2	☐R ☐L	☐Upper Arm ☐Thigh ☐Deltoid ☐Vastus Lat	☐SC ☐IM			
☐PCV 20	0.5 mL ☐1☐ 2☐ 3☐ 4	☐R ☐L	☐Deltoid ☐Vastus Lat	☐IM			
☐Polio/IPV	0.5 mL ☐1 ☐2 ☐3 ☐4 ☐5	☐R ☐L	☐Deltoid ☐Upper Arm ☐Thigh	☐IM ☐SC			
☐Rotavirus	2.0 mL ☐1 ☐ 2 ☐3		☐By Mouth	☐Oral			
☐RSV	Adult ☐ 0.5 mL ☐1	☐R ☐L	☐Deltoid ☐Vastus Lat	☐IM			
☐Shingles	0.5 mL ☐1 ☐ 2	☐R ☐L	☐Deltoid	☐IM			
☐Tdap ☐Td	0.5 mL Series # __	☐R ☐L	☐Deltoid	☐IM			
☐Varicella	0.5 mL ☐1 ☐ 2	☐R ☐L	☐Upper Arm ☐Deltoid ☐Vastus Lat	☐IM ☐SQ			

Signature and Title of Vaccine Administrator

Date