VACCINE DOCUMENTATION/CONSENT FORM

I have been offered a copy of the "Vaccine Information Statement(s)" checked below. I have read, have had explained to me and understand, the information in the "Vaccine Information Statement(s)". I ask that the vaccine(s) checked below be given to me or to the person named below for whom I the parent or guardian or am otherwise authorized to make this request. I consent to inclusion of this immunization data in the Kansas Immunization Registry for myself and on behalf of the person named below.

☐ DTaP/DT/TdaP/Td ☐ HepA ☐ HepB ☐ Hib ☐ HPV ☐ Influenza ☐ Meningococcal ☐ MMR

☐ PCV13 ☐ PPV23 ☐ Polio/IPV ☐ Rotavirus ☐ Tb ppd ☐ Varicella Other _____

Signature of Patient or Parent/Guardian _____ Date _____

PATIENT INFORMATION

Patient's Last Name:	Patient's First Name:	(ID):	Phone Number:	Age:	Birth Date	Gender	Ethnicity: Hispanic or Latino
						[ ] MALE [ ] FEMALE	[ ] Yes [ ] No

PATIENT ADDRESS	PHYSICIAN	PATIENT ELIGIBILITY * ** ^	RACE (Select one or more.)
Address: County:	Primary Care Physician: Physician Contact Information:	☐ TITLE 19 (Medicaid) ☐ Uninsured ☐ American Indian/Alaskan Native ☐ Underinsured ☐ Not VFC Eligible ☐ 317 ☐ Medicare ☐ State ☐ Title 21 (CHIP)	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ Unknown or Not Reported ☒ White ☐ Other

*Underinsured children: Insurance does not cover immunizations. Eligible through VFC program if vaccinated at a FQHC, RHC, or county health dept.

**Underserved children: Are not VFC Eligible. May only be vaccinated with KIP vaccines needed for school entry at a county health dept if enrolled in federal free or reduced-price school lunch program.

^ Underserved and Underinsured children are eligible through state funded vaccine program if vaccinated at a public county health clinic.

IMMUNIZATION SCREENING QUESTIONNAIRE

1. Is the patient to be vaccinated currently sick or experiencing a high fever?	☐ Yes ☐ No	7. Has the patient, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐ Yes. ☐ No
2. Does the patient have allergies to medications, food, a vaccine component, or latex?	☐ Yes ☐ No	8. Does the patient have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐ Yes. ☐ No
3. Has the patient had a serious reaction to a vaccine in the past?	☐ Yes ☐ No	9. In the past 3 months, has the patient taken medications that weaken their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?	☐ Yes. ☐ No
4. Has the patient had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	☐ Yes ☐ No	10. 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
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	11. Is the patient pregnant or is there a chance she could become pregnant during the next month?	☐ Yes. ☐ No
6. If your patient is a baby, have you ever been told he or she has had intussusceptions?	☐ Yes ☐ No	12. Has the patient received vaccinations in the past 4 weeks?	☐ Yes. ☐ No

PROVIDER INFORMATION

Vaccine Provider: CLARA BARTON MEDICAL CLINIC (6318) PHL7		Clinic Site: CLARA BARTON MEDICAL CLNC (CLRA BTN MD)	
Address: 252 W 9TH HOISINGTON, KS 67544		Address: 252 W 9TH ST HOISINGTON, KS 67544	
Phone Number: 620-653-2386x288	County: BARTON	Phone Number: 620-653-2386	County: BARTON