

CHILD (0-18 YEARS OF AGE) VACCINE DOCUMENTATION/CONSENT FORM

I have been offered a copy of the Vaccine Information Statement(s) (VIS) checked below. I have read, had explained to me, and understand the information in the VIS(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 Registry for myself or on behalf of the person named below.

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|------------------------------------|---|---------------------------------------|--------------------------------------|---|--|--|
| <input type="checkbox"/> DTaP | <input type="checkbox"/> Td | <input type="checkbox"/> Tdap | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Meningococcal B | <input type="checkbox"/> Meningococcal (A,C,Y,W-135) |
| <input type="checkbox"/> MMR | <input type="checkbox"/> Varicella | <input type="checkbox"/> MMR-V | <input type="checkbox"/> Polio/IPV | <input type="checkbox"/> Hib | <input type="checkbox"/> Prevnar 13 | <input type="checkbox"/> PPSV23 |
| <input type="checkbox"/> Influenza | <input type="checkbox"/> DTaP/IPV/Hep B | <input type="checkbox"/> DTaP/Hib/IPV | <input type="checkbox"/> DTaP/IPV | <input type="checkbox"/> Gardasil (4,9) | <input type="checkbox"/> Rotavirus | <input type="checkbox"/> Other: _____ |

Signature of Patient or Parent/Guardian

Date

Date:	Patient's First Name:	Middle Name:	Last Name:	Maiden Name/Alias:
Birth Date:	Age:	Social Security Number:		Primary Language:
Ethnicity: Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No		Race: (Select one or more.)		
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Asian/Pacific Islander/Other <input type="checkbox"/> Black or African American <input type="checkbox"/> Caucasian or White <input type="checkbox"/> Hawaiian <input type="checkbox"/> Native American/Alaska Native <input type="checkbox"/> Unknown or Other _____		
Mailing Address:			City:	State:
			County:	Zip Code:
Phone Number: Verizon __ Sprint __ T-Mobile __ AT&T __ Other: _____ Text Reminders: Yes _ No_			Email Address: @yahoo.com @hotmail.com @gmail.com @ksu.edu @cox.net Email Reminders: Yes _ No_	
Mother's First Name:		Mother's Last Name:		Doctor:
				Child's School:

INSURANCE INFORMATION

Please fill out the following information completely AND submit a copy of your insurance card.

<u>PRIMARY INSURANCE</u>	Policy Holder Name _____ Birthdate _____ Patient relationship to policy holder: Self Spouse Child Other _____ ID# _____ Group # _____
<u>SECONDARY INSURANCE</u>	Policy Holder Name _____ Birthdate _____ Patient relationship to policy holder: Self Spouse Child Other _____ ID# _____ Group # _____

PATIENT ELIGIBILITY

<input type="checkbox"/> T19-MED	<input type="checkbox"/> No health insurance	<input type="checkbox"/> Native Am/Alaska Native	<input type="checkbox"/> Underinsured*	<input type="checkbox"/> Underserved**	<input type="checkbox"/> T21-SCHIP	<input type="checkbox"/> Fully Insured
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IMMUNIZATION SCREENING QUESTIONNAIRE

1. Is the patient to be vaccinated currently sick or experiencing a high fever?	Yes	No
2. Does the patient have allergies to medications, food, a vaccine component, or latex? List:	Yes	No
3. Has the patient had a serious reaction to a vaccine in the past? Please explain:	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
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
6. If the person to be vaccinated between 2 and 17 years and receiving aspirin therapy or aspirin-containing therapy?	Yes	No
7. If the patient is a baby, have you ever been told he or she has had intussusceptions?	Yes	No
8. Has the patient, a sibling, or a parent had a seizure?	Yes	No
9. Has the patient ever had a brain disorder, Guillain-Barré syndrome, or other nervous system problem?	Yes	No
10. Does the patient have cancer, leukemia, HIV/AIDS, or any other immune system problem?	Yes	No
11. 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
12. 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
13. Is the patient pregnant or is there a chance she could become pregnant during the next month?	Yes	No
14. Is the patient planning to travel out of the United States? Location(s):	Yes	No
15. Has the patient received vaccinations in the past 4 weeks?	Yes	No

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FOR CLINICAL USE ONLY							
VACCINE	DOSE	EXT	SITE	ROUTE	VIS DATE	MANUFACTURE R LOT #	EXP DATE
DTaP DT Td Tdap	0.5 mL 1 2 3 4 5 6	RT LT	Deltoid Vastus Lat	IM	DTaP 05/17/07 Td 02/24/15 Tdap 02/24/15		
DTaP/IPV (Kinrix/Quadracel)	0.5 mL 5th DTaP--4th IPV (Kinrix)	RT LT	Deltoid Vastus Lat	IM	DTaP 05/17/07 IPV 07/20/16		
DTaP/HepB/IPV (Pediarix)	0.5 mL 1 2 3	RT LT	Deltoid Vastus Lat	IM	DTaP 05/17/07 HepB 07/20/16 IPV 07/20/16 Combo 11/05/15		
DTaP/Hib/IPV (Pentacel)	0.5 mL 1 2 3 4	RT LT	Deltoid Vastus Lat	IM	DTaP 05/17/07 Hib 04/02/15 IPV 07/20/16 Combo 11/05/15		
Hepatitis A	0.5 mL 1.0 mL 1 2	RT LT	Deltoid Vastus Lat	IM	HepA 07/20/16		
Hepatitis B	0.5 mL 1.0 mL 1 2 3	RT LT	Deltoid Vastus Lat	IM	HepB 07/20/16		
Hib	0.5 mL 1 2 3 4	RT LT	Deltoid Vastus Lat	IM	Hib 04/02/15		
HPV (Gardasil 4, 9)	0.5 mL 1 2 3	RT LT	Deltoid	IM	Gardasil 4 05/17/13 Gardasil 9 03/31/16		
Influenza IIV4	0.25mL 0.50mL 1 2	RT LT	Deltoid Vastus Lat	IM	Inactivated 08/07/15		
MCV4/MPSV4 (Menveo/Menactra)	0.5 mL 1 2	RT LT	Deltoid	IM	Meningococcal 03/31/16		
Meningococcal B	0.5 mL	RT LT	Deltoid	IM	MenB 08/09/16		
MMR	0.5 mL 1 2	RT LT	Upper Arm Thigh	SC	MMR 04/20/12		
MMRV (ProQuad)	0.5 mL 1 2	RT LT	Upper Arm Thigh	SC	MMRV 05/21/10		
PCV13 (Prevnar 13)	0.5 mL 1 2 3 4	RT LT	Deltoid Vastus Lat	IM	Pneumococcal Conjugate 11/05/15		
Polio/IPV	0.5 mL 1 2 3 4 5	RT LT	Upper Arm Thigh	IM SC	IPV 07/20/16		
PPV23	0.5 mL 1 2	RT LT	Deltoid Vastus Lat	SC IM	Pneumococcal Polysaccharide 04/24/15		
Rotavirus (Rotarix/RotaTeq)	2.0 mL 1 2 3		By Mouth	Oral	Rotavirus 04/15/15		
Varicella	0.5 mL 1 2	RT LT	Upper Arm Thigh	SC	Chickenpox 03/13/08		
Typhim Vi (≥ 2 years) Vivotif (≥ 7 years)	0.5 mL 1 2	RT LT	Deltoid Vastus Lat	IM PO (oral)	Typhoid 05/29/12		
Yellow Fever (9 months – 59 years)	0.5 mL 1 2	RT LT	Upper Arm Thigh	SC	Yellow Fever 03/30/11		
Japanese Encephalitis (2 months and older)	0.5 mL 1 2	RT LT	Deltoid Vastus Lat	IM	J. Encephalitis 01/24/14		
Pre-Exposure Rabies	0.5 mL 1 2 3	RT LT	Deltoid Vastus Lat	IM	Pre-Exposure Rabies 10/06/09		

Signature and Title of Vaccine Administrator

Date