**Community Health Center of Southeast Kansas**

VFC ☐
CHIP ☐
PRIVATE ☐

## VACCINE DOCUMENTATION/CONSENT FORM

| Patient's Last Name | First Name | Phone Number | Age | Date of Birth |
|---|---|---|---|---|
| | | | | |

| Street Address | City | County | State | Zip Code |
|---|---|---|---|---|
| | | | | |

| Male Female | Primary Care Physician's Name | Hispanic or Latino? |
|---|---|---|
| | | |

**Race: (Select one or more)**

- ❑Asian/Pacific Islander
- ❑Black or African American
- ❑Caucasian/Mexican/Puerto Rican
- ❑Chinese
- ❑Filipino
- ❑Hawaiian
- ❑Native American/Alaska Native
- ❑Japanese
- ❑Other Non-White
- ❑Unknown

**Type of Coverage?**

- ❑No health insurance
- ❑Medicaid/KANCARE
- ❑Commercial Insurance
- ❑Native Am/Alaska Native

If you have commercial insurance, are immunizations fully covered? ___Yes ___No

| | |
|---|---|
| Is the person to be vaccinated currently sick or experiencing a high fever? | |
| Has the person to be vaccinated had a serious reaction to a vaccine in the past? | |
| Does the person to be vaccinated have any allergies that produce a severe reaction? | |
| Has the person to be vaccinated had a seizure or other neurological problem? | |
| Does the person to be vaccinated have medical problems that make it hard to fight infection? | |
| Does this person have close contact with someone with a weakened immune system? | |
| Is the person taking cortisone, prednisone, other steroids or anti-cancer drugs, or had x-ray treatments? | |
| Has the person received blood, plasma or immune globulin in the past 12 months? | |
| Is the person to be vaccinated pregnant or thinking of becoming pregnant within the next three months? | |

❑ I consent to the 3-dose series for the *HPV Vaccine.

*HPV vaccine protects against cancers caused by the Human Papillomavirus.

**Second dose due**_____ **Third dose due** _____

**Day/ Month** **Day/Month**

**I have been given a copy of the Vaccine Information Statements. I have read, had explained to me and understand the information in these statements. I ask that the vaccine(s) be given to me or to the person 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. I also consent to CHCSEK sharing vaccine records with schools in order to comply with school requirements.**

School Child Attends:_____

_____ _____

Signature of Patient or Parent/Guardian Date CHC/SEK Immunization Provider Date

Patient Name_____ DOB_____ Date _____

| VACCINE TYPE | VACCINE BRAND | DOSE | EXT | SITE | ROUTE | VIS DATE | LOT# NDC# | EXP DATE |
|---|---|---|---|---|---|---|---|---|
| DTaP | Infanrix | 1 2 3 4 5 | RT LT | Deltoid Vastus Lat | IM | | | |
| TDap | Adacel Boostrix | 1 2 3 4 5 6 | RT LT | Deltoid Vastus Lat | IM | | | |
| DTAP/IPV | Kinrix | 4 5 | RT LT | Deltoid Vastus Lat | IM | | | |
| DTaP/HepB/IPV | Pediarix | 1 2 3 | RT LT | Deltoid Vastus Lat | IM | | | |
| Hep A | Havrix | 1 2 3 | RT LT | Deltoid Vastus Lat | IM | | | |
| Hep B | Engerix B | 1 2 3 | RT LT | Deltoid Vastus Lat | IM | | | |
| Hib | Pedvax | 1 2 3 4 | RT LT | Deltoid Vastus Lat | IM | | | |
| HPV | Gardasil Gardasil 9 | 1 2 3 | RT LT | Deltoid | IM | | | |
| MCV4 | Menactra Menveo | 1 2 | RT LT | Deltoid | IM | | | |
| MenB | Bexsero | 1 2 | RT LT | Deltoid | IM | | | |
| MMR | MMR | 1 2 | RT LT | Upper Arm Thigh | SQ | | | |
| MMR-V | ProQuad | 1 2 | RT LT | Upper Arm Thigh | SQ | | | |
| PCV/13 | Prevnar | 1 2 3 4 | RT LT | Deltoid Vastus Lat | IM | | | |
| Polio/IPV | EIPV | 1 2 3 4 | RT LT | Upper Arm Thigh | SQ | | | |
| PPV23 | PPV23 | 1 2 | RT LT | Deltoid Vastus Lat | IM | | | |
| Rotavirus | RotaTeq | 1 2 3 | RT LT | By mouth | Oral | | | |
| Varicella | Varivax | 1 2 | RT LT | Upper Arm Thigh | SQ | | | |
| Adult HepA | Havrix | 1 | RT LT | Deltoid | IM | | | |
| Adult HepA & B | Twinrix | 1 | RT LT | Deltoid | IM | | | |
| Adult B | Engerix | 1 | RT LT | Deltoid | IM | | | |
| Other | | | | | | | | |