Community Health Center of Southeast Kansas

VFC ☐ PRIVATE ☐

CHIP ☐ UNINSURED ADULT ☐

VACCINE DOCUMENTATION/CONSENT FORM

Patient's Last Name	First Name	Phone Number	Age	DOB

Street Address	City	County	State	Zip Code

Male Female	Primary Care Physician's Name	Hispanic or Latino? Yes No

Race: (Select one or more)
❑Native American\Alaska Native ❑Asian
❑Black or African American ❑Native Hawaiian \ Pacific Islander
❑Caucasian\White ❑Mexican/Puerto Rican
❑Other Non-White ❑Unknown

Type of Coverage?
❑Uninsured ❑Commercial Insurance ❑Medicaid/KANCARE ❑Native Am/Alaska Native
If you have commercial insurance, are immunizations fully covered? ___Yes ___No ___Unknown

Please read carefully and answer the following health questions:

1. Is the person to be vaccinated currently sick or have a fever higher than 100.4°F?	Yes	No
2. Has the patient received immunizations in the past 4 weeks? Specify:	Yes	No
3. Does the patient have any allergies to medications, food, vaccine components, or latex?	Yes	No
4. Has the patient had a serious reaction to a vaccine in the past? Specify:	Yes	No
5. Has the patient had health problems with lungs, heart, kidney, or metabolic disease (e.g. diabetes), asthma, or a blood disorder? Is patient on long term aspirin therapy?	Yes	No
6. If the patient to be vaccinated is between age 2 and 4 years, has a healthcare provider told you the child had wheezing or asthma in the last 12 month?	Yes	No
7. If the patient is an infant, have you ever been told he or she has had intussusceptions?	Yes	No
8. Has the person to be vaccinated had a seizure or other brain or neurological problems?	Yes	No
9. Does the patient have cancer, leukemia, HIV/AIDS, or other immune system problems?	Yes	No
10. In the last 3 months, has the patient received any treatment that might weaken his or her immune system such as steroids, anti-cancer drugs, chemotherapy, or radiation?	Yes	No
11. In the past 12 months has the patient had a transfusion of blood, blood products, or been given immune globulin? Or has the patient taken any antiviral drugs like acyclovir?	Yes	No
12. Does this person have close contact with someone with a weakened immune system?	Yes	No
13. Is the patient pregnant or may become pregnant in the next month?	Yes	No
14. Has the patient ever had Guillain Barré syndrome?	Yes	No

Circle today's recommended vaccine:

DTaP **Tdap** **Pediarix** (Dtap-IPV-HepB) **Kinrix** (Dtap-IPV) **HepA** **HepB** **HIB**
HPV **MMR** **MCV4** **MenB** **PCV13** **PPV23**
Polio **Rotavirus** **Varicella** **ProQuad** (MMR+VAR) **Influenza** **Other:**_____

Acknowledgement: The Vaccine Information Statement(s) (VIS) for the above selected vaccine(s) have been made available to me. I have read, had explained to me and understand the information in these statements. I ask 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

Revised: 9/6/2020

Patient Name_____ DOB_____ Date _____

Labels from administered vaccine(s) are to be affixed for accurate documentation of lot numbers and expiration dates.

VACCINE TYPE	VACCINE BRAND	DOSE	EXT	SITE	ROUTE	VIS DATE	LOT# NDC#	EXP DATE
DTaP	**Infanrix** Daptacel	**1 2 3** **4 5**	**RT** **LT**	**Deltoid** **Vastus Lat**	**IM**	4/1/20		
TDap	**Boostrix** Adacel	**1 2 3** **4 5 6**	**RT** **LT**	**Deltoid** **Vastus Lat**	**IM**	4/1/20		
DTAP/IPV	**Kinrix** Quadricel	**4 5**	**RT** **LT**	**Deltoid** **Vastus Lat**	**IM**	4/1/20		
DTaP/HepB/IPV	**Pediarix**	**1 2 3**	**RT** **LT**	**Deltoid** **Vastus Lat**	**IM**	4/1/20		
DTap/IPV/HIBa	Pentacel	**1 2 3 4**	**RT** **LT**	**Deltoid** **Vastus Lat**	**IM**	4/1/20		
Hep A	**Havrix** Vaqta	**1 2 3**	**RT** **LT**	**Deltoid** **Vastus Lat**	**IM**	7/28/20		
Hep B	**Engerix-B** Recombivax HB	**1 2 3**	**RT** **LT**	**Deltoid** **Vastus Lat**	**IM**	8/15/19		
HIB	**PedvaxHIB** ActHIB	**1 2 3 4**	**RT** **LT**	**Deltoid** **Vastus Lat**	**IM**	10/30/19		
HPV	**Gardasil 9**	**1 2 3**	**RT** **LT**	**Deltoid**	**IM**	10/30/19		
MCV4 (ACWY)	**Menactra** Menveo	**1 2**	**RT** **LT**	**Deltoid**	**IM**	8/15/19		
MenB	**Bexsero**	**1 2**	**RT** **LT**	**Deltoid**	**IM**	8/15/19		
MMR	**MMR**	**1 2**	**RT** **LT**	**Upper Arm** **Thigh**	**SQ**	8/15/19		
MMR-V	**ProQuad**	**1 2**	**RT** **LT**	**Upper Arm** **Thigh**	**SQ**	8/15/19		
PCV/13	**Prevnar**	**1 2 3 4**	**RT** **LT**	**Deltoid** **Vastus Lat**	**IM**	10/30/19		
Polio/IPV	**Polio**	**1 2 3 4**	**RT** **LT**	**Upper Arm** **Thigh**	**SQ**	10/30/19		
PPSV23	**Pneumovax**	**1 2**	**RT** **LT**	**Deltoid** **Vastus Lat**	**IM**	10/30/19		
Rotavirus	**RotaTeq** Rotarix	**1 2 3** 1 2	**PO**	**By mouth**	**Oral**	10/30/19		
Varicella	**Varivax**	**1 2**	**RT** **LT**	**Upper Arm** **Thigh**	**SQ**	8/15/19		
Adult HepA	**Havrix** Vaqta	**1 2**	**RT** **LT**	**Deltoid**	**IM**	7/28/20		
Adult HepA & B	**Twinrix**	**1 2**	**RT** **LT**	**Deltoid**	**IM**	8/15/19		
Adult Hep B	**Engerix-B** Recombivax HB	**1 2 3**	**RT** **LT**	**Deltoid**	**IM**	8/15/19		
Influenza	**Flulaval** Fluzone Other: _____	**1 2 3+**	**RT** **LT**	**Deltoid** **Vastus Lat**	**IM**	8/15/19		
High Dose Flu	**Fluzone High Dose**	**1**	**RT** **LT**	**Deltoid**	**IM**	8/15/19		
Other:								

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