**Vaccine Documentation and 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)/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 give permission for this information to be released to the Kansas Immunization Information System. I have been offered a copy of the Sumner County Health Department's Notice of Privacy Practices. I understand if my insurance claim(s) are denied or if I have insurance co-pays, I am responsible for prompt payment.

☐Influenza: ☐High Dose ☐FluBlok ☐Regular: Fluarix

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|  | | | | **Patient Information** | | | | | | | | | | | | | |
| **Patient’s Last Name: Pa** | | | | **ttient’s First Name:** | | | | | | **Phone Number:** | | **Age:** | | | | **Birth Date:** | |
| **Street Address:** | | | |  | **City:** | | | | | **County:** | | **State:** | | | **Zip Code:** | | |
| **Gender:**  ☐Male ☐Female | | | | **Ethnicity:**  ☐Hispanic or Latino  ☐Not Hispanic or Latino  ☐Unknown | | **Race:** (Select one or more.)  ☐American Indian/Alaskan Native ☐Native Hawaiian or Other Pacific Islander  ☐Asian ☐Other Non-White  ☐Black or African American ☐Unknown  ☐Caucasian/White | | | | | | | | | | | |
| **Primary Care Physician:** | | | |
| **Medicaid#:** | | | |  | | | | **Medicare#:** | | | | | | | | | |
|  | | | | **PAYOR SOURCE** | | | | | | | | | | | | | |
| ☐M-Care | | ☐RR M-Care | ☐Medicaid | ☐Insurance | | | ☐317 | | ☐Business | | ☐Sumner Co. | ☐PP | | | | ☐Other | |
| **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. Has the patient, a sibling, or a parent had a seizure; had brain or other nervous system problems? | | | | | | | | | | | | | | ☐Yes ☐No ☐Don’t know | | | |
| 6. Does the patient have cancer, leukemia, HIV/AIDS, or any other immunocompromising condition? | | | | | | | | | | | | | | ☐Yes ☐No ☐Don’t know | | | |
| 7. Does the patient have a parent, brother, or sister with an immune system problem? | | | | | | | | | | | | | | ☐Yes ☐No ☐Don’t know | | | |
| 8. 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 | | | |
|  | | | |
| 9. 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 | | | |
| 10. Is the patient pregnant or is there a chance of becoming pregnant during the next month? | | | | | | | | | | | | | | ☐Yes ☐No ☐Don’t know | | | |
| 11. Has the patient received vaccinations in the past 4 weeks? If yes: | | | | | | | | | | | | | | ☐Yes ☐No ☐Don’t know | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| Signature of Patient or Parent/Guardian | | | | | | | | | | | | Date | | | |

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|  |  | **Provider Information** | | |  |  |
| Vaccine Provider: |  |  | | Clinic Site: |  |  |
| Street Address: | State: | Zip Code: | Street Address: | | State: | Zip Code: |

(Mark the appropriate vaccine, dose, extremity, site, route, enter the manufacturer, lot #, expiration date, VIS or EUA Fact Sheet date.)

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| **For Clinical Use Only** | | | | |  | |  | | |
| **VACCINE** | **DOSE** | **EXT** | **SITE** | **ROUTE** | **VIS/EUA REV DATE** | | **MANUFACTURER LOT**  **NUMBER** | **EXP DATE** | |
| ☐Influenza  2025-2026 | ☐ \_\_\_\_\_\_\_\_\_\_\_\_ | ☐R  ☐L | ☐Deltoid  ☐Vastus Lat | ☐IM |  | |  |  | |
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| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature and Title of Vaccine Administrator | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date | | |
|  | | | | | | Rev. 9/2025 | | |