Sedgwick County Division of Health 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 that vaccine(s) checked below be given to me or 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.

ACKNOWLEDGEMENT OF "NOTICE" OF PRIVACY PRACTICES:

I acknowledge that a copy of Sedgwick County's "Notice" of Privacy Practices has been made available to me with the effective date of July 1, 2013.

INSURANCE AUTHORIZATION AND RELEASE OF INFORMATION

I request that payment of authorized Medical Benefits billed to insurance (including Medicare, Medicaid, and KanCare) be made on my behalf to Sedgwick County Division of Health for any services furnished to me by that facility. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid services (CMS) and its agents any information needed to determine these benefits payable for related services. Sedgwick County Division of Health files insurance as a courtesy. This constitutes advance notice to you, the beneficiary, that if all program requirements are met by the provider but payment is not made by Medicaid and/or any other insurance coverage, you may be held responsible for the charges.

☐	Dtap	☐	Hep A	☐	MMR	☐	Rotavirus	☐	Immune Globulin	☐	Other _____
☐	Tdap	☐	Hep B	☐	Meningococcal	☐	Shingles	☐	Rabies	☐	Other _____
☐	TD	☐	Hib	☐	Pneumonia	☐	Varicella	☐	Typhoid	☐	Other _____
☐	DT	☐	HPV	☐	Polio	☐	Influenza	☐	Yellow Fever	☐	Other _____

Signature of Patient or Parent/Guardian _____ **Date** _____

Printed name of Patient or Parent/Guardian _____ **Parent DOB** _____

Relationship to Patient _____

AUTHORIZATION TO CONTACT - Please initial and check all that apply

_____ This information may be used to contact me regarding appointment or vaccination reminders for myself or those for whom I am the parent or guardian.

☐ Phone ☐ Text ☐ Mail ☐ Email (please provide email address) _____

Patient Information

Last Name	First Name	Phone Number	Age	Birth Date
Street Address		**City**	**State**	**Zip Code**

	Hispanic or Latin	Race
	Yes___ No___	__ Asian __ Native American/Alaska Native
Primary Care Physician	Gender	__ Black or African American __ Other
	M ____ F ____	__ Caucasian/Mexican/Puerto Rican __ Native Hawaiian/Pacific Islander

Immunization Screening Questionnaire

1. Is the person to be vaccinated currently sick or experiencing a high fever?	_____ Yes	____ No
2. Has the person to be vaccinated had a serious reaction to a vaccine in the past?	_____ Yes	____ No
3. Does the person to be vaccinated have any allergies that produce a severe (anaphylactic) reaction?	_____ Yes	____ No
4. Has the person to be vaccinated had a seizure or other neurological problems?	_____ Yes	____ No
5. Does the person to be vaccinated have any medical problems that make it hard for him/her to fight infection?	_____ Yes	____ No
6. Does the person to be vaccinated have close, regular contact with someone who has a weakened immune system?	_____ Yes	____ No
7. Is the person taking cortisone, prednisone, other steroids, or anti-cancer drugs, or had x-ray treatments?	_____ Yes	____ No
8. Has the person to be vaccinated received blood, plasma, or immune globulin in the past twelve months?	_____ Yes	____ No
9. Is the person to be vaccinated pregnant or thinking of becoming pregnant within the next three months?	_____ Yes	____ No
10. What date did you begin your last menstrual cycle? Date: _____	N/A	
11. Do you smoke?	_____ Yes	____ No
If so, do you plan on quitting within the next 30 days?	_____ Yes	____ No

Patient Eligibility

____ T19 ____ No Health Insurance ____ Native American/Alaska Native ____ T21 ____ Fully Insured

____ Underinsured (Insurance does not cover immunizations)

____ Underserved (Insurance co-pay or deductible high enough to provide a barrier to immunizations)