

**Place Label Here
Pediatric - SLV**

Reno County Health Department

Vaccine Documentation Form

Off Site

SLV

Amerigroup Sunflower	United Healthcare	**PRIVATE-VACCINE**
Title-19 <input type="checkbox"/>	CHIP-21 <input type="checkbox"/>	Commercial Ins: <input type="checkbox"/>
NO INSURANCE COVERAGE **VFC VACCINE**		TTP-Third Party Pay: <input type="checkbox"/>
No Insurance Insufficient	American Indian Alaska Native	
Insurance Policy Number	# in Family:	

*****Client Information*****

Last Name		Name		MI	Responsible Party	
Date of Birth	Age	Sex	SSN		Responsible Party SSN	Responsible Party Date of Birth:
Address			Phone		Responsible Party Phone	
City		State	Zip		Physician's Phone	Physician
Race	<input type="checkbox"/> White	<input type="checkbox"/> African American	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Hawaiian/Pacific Islander	
Hispanic or Latino	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Choose One:	<input type="checkbox"/> Mexican	<input type="checkbox"/> Cuban	<input type="checkbox"/> Puerto Rican
				<input type="checkbox"/> Central/South American		

Immunization Screening Questionnaire

1. Is the person to be vaccinated currently sick or experiencing a high fever?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Does the child have allergies to medications, food, latex, or a vaccine component?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Has the child had a serious reaction to a vaccine in the past?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Has the child had a health problem with the lungs, heart, kidneys, or metabolic disease (e.g. diabetes, asthma, or a blood disorder)? Is he/she on a long-term aspirin therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. If the child 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. If your child is a baby, have you ever been told he or she has had intussusception?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Does the child to be vaccinated have close, regular contact with someone with a weakened immune system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. In the past 3 months, has the child taken medications that weaken their immune system, such as cortisone, prednisone, other steroids, antiviral medications, anticancer drugs, or had radiation treatments.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Has the child to be vaccinated received blood, plasma, or immune globulin in the past twelve months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13. Has the child received vaccinations in the past 4 weeks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

* I have been given a copy and have read, or have had explained to me, the information in the Vaccine Information Statement ("VIS") and ask that the vaccine(s) be given to me or to the person named for who I am authorized to make this request. I consent to the inclusion of immunization data in the Kansas Immunization Registry.

* I acknowledge that I have been offered a copy of the Reno County Health Department's Notice of Privacy Practices with the effective date of 09/25/2013.

* I authorize the release of the medical or billing information necessary to process claims for insurance providers including Medicare.

NOTE: According to Kansas Statute 65-531

Information and records which pertain to the immunization status of persons against childhood diseases as required by K.S.A. 65-508 and 65-519 may be disclosed and exchanged without a parent or guardian's written release authorizing such disclosure to those who need such information to assure compliance with state statutes or to achieve age appropriate immunization status for children. See State Statute 65-531 for complete description.

Client's Name _____

Date _____

Signature of Client/Parent/Guardian _____

Date _____

Signature of Health Care Worker _____

Date _____