## Sedgwick County Health Department Vaccine Documentaton/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 Health Department 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 Health Dept. 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 | ☐ | Meningococcal | ☐ | Pneumonia |
| ☐ | Tdap | ☐ | Hep B | ☐ | Varicella | ☐ | HPV | ☐ | Influenza |
| ☐ | TD | ☐ | Hib | ☐ | Rotavirus | ☐ | Yellow Fever | ☐ | Immune Globulin |
| ☐ | DT | ☐ | Prevnar | ☐ | Polio | ☐ | Typhoid | ☐ | Other ______________________________ |
| ☐ | Rabies | ☐ | Shingles | | | | | | |

**Signature of Patient or Parent/Guardian** ____________________________________ **Date** ______________________

**Printed name of Patient or Parent/Guardian** ______________________________ **Parent DOB** ____________________

**Relationship to Patient** _________________________________

| Patient Information | | | | |
|---|---|---|---|---|
| Last Name | First Name | Phone Number | Age | Birth Date |
| Street Address | | City | State | Zip Code |
| Social Security # | Hispanic or Latin<br>Yes___ No___ | Race<br>__ Asian<br>__ Black or African American<br>__ Caucasian/Mexican/Puerto Rican | __ Native American/Alaska Native<br>__ Other<br>__ Native Hawaiian/Pacific Islander | |
| Primary Care Physician | Gender<br>M ____ F ____ | | | |

This information may be used to contact me regarding an appointment reminder for myself or those I am Guardian of.

| 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? | _____ Yes | ____ No |
| 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)