Sedgwick County Health Department 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 April 14, 2003

INSURANCE AUTHORIZATION AND RELEASE OF INFORMATION

I request that payment of authorized Medical Benefits billed to insurance (including Medicare, Medicaid, and HealthWave) 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** _____

Patient Information				
Last Name:	First Name:	Phone Number:	Age:	Birth Date:
Street Address:		City:	State:	Zip Code:

Social Security #:	Hispanic or Latino: Yes____ No____	Race:
Primary Care Physician:	Gender: Female____ Male____	_____ Asian/Pacific Islander _____ Native American/Alaska Native _____ Black or African American _____ Other _____Caucasian/Mexican/Puerto Rican _____ Unknown

Email Address_____

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

Patient Eligibility

____ Medicaid ____ No Health Insurance ____ Native American/Alaska Native ____ HealthWave ____Fully Insured

____ Underinsured (Insurance does not cover immunizations)

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

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?	_____	N/A
11. Do you smoke?	____ Yes	____ No
If so, do you plan on quitting within the next 30 days?	____ Yes	____ No