Place Label Here
Pediatric

Reno County Health Department
Vaccine Documentation Form
Office Use Only

IAP Site:

VFC VACCINE				***PRIVATE***
Amerigroup - Sunflower - United Healthcare				TPP-Third Party Pay:
Title - 19		CHIP-21		
No Insurance	☐	American Indian	☐	Commercial Insurance
Underinsured	☐	Alaska Native	☐	

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

Last Name		Name	MI	Insurance Policy #	# in Family
Date of Birth	Age	Sex		Responsible Party	
Address		Phone		Responsible Party Date of Birth:	
City	State	Zip		Responsible Party Phone #	
				Physician	Physician's Phone

Race ☐ White ☐ African American ☐ American Indian/Alaska Native ☐ Asian ☐ Hawaiian/Pacific Islander

Hispanic or Latino ☐ YES ☐ NO Choose One: ☐ Mexican ☐ Cuban ☐ Puerto Rican ☐ Central/South American

Immunization Screening Questionnaire

1. Is the person to be vaccinated currently sick or experiencing a high fever?	☐ Yes ☐ No
2. Does the child have allergies to medications, food, latex, or a vaccine component?	☐ Yes ☐ No
3. Has the child had a serious reaction to a vaccine in the past?	☐ Yes ☐ 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?	☐ Yes ☐ 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?	☐ Yes ☐ No
6. If your child is a baby, have you ever been told he or she has had intussusception?	☐ Yes ☐ No
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐ Yes ☐ No
8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐ Yes ☐ No
9. Does the child to be vaccinated have close, regular contact with someone with a weakened immune system?	☐ Yes ☐ 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.	☐ Yes ☐ No
11. Has the child to be vaccinated received blood, plasma, or immune globulin in the past twelve months?	☐ Yes ☐ No
12. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐ Yes ☐ No
13. Has the child received vaccinations in the past 4 weeks?	☐ Yes ☐ No

I acknowledge that I have been offered a copy of the Reno County Health Department's Notice of Privacy Practices.

I authorize the release of the medical or billing information necessary to process claims for insurance providers including Medicare. I have been informed that if I provide a copy of my Health Insurance or Medicare card, a claim for service will be submitted to my insurance provider. If an insurance claim is denied, services will be billed to me at full charge unless the Income Documentation section has been completed and qualifies me for a reduced rate.

I request payment of insurance benefits to the Reno County Health Department.

I consent to the inclusion of immunization data in the Kansas Immunization Registry.

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.

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.

I acknowledge that I am refusing the following recommended vaccinations: _____

Signature of Parent or Guardian _____ Date _____

Signature of Health Care Worker	Date