# 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 the vaccine(s) checked below be given to me or to 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.

Influenza

Signature_____Date_____

Parent/Guardian Signature for Student / Patient Signature if Adult

| PATIENT INFORMATION | | | | |
|---|---|---|---|---|
| **Patient's Last Name:** **Patient's First Name:** | | **Phone Number:** | **Age:** | **Birth date:** |
| **Street Address:** | **City:** | **County:** | **State:** | **Zip Code:** |

**Ethnicity:** Hispanic or Latino
___ Yes ___ No

**Gender**
___ Male ___ Female

**Race:** (Select one or more.)
___ AS-Asian/Pacific Islander/Other
___ BL-Black or African American
___ CA-Caucasian
___ CH-Chinese
___ FI-Filipino
___ HA-Hawaiian
___ IN-Native American/Alaska Native
___ JA-Japanese
___ NW-Other Non-White
___ UN-Unknown

**Primary Care Physician:**

1. Has the patient received vaccinations in the past 4 weeks? YES NO
2. Has the person to be vaccinated ever had Guillian-Barre' syndrome? YES NO
3. Has the person to be vaccinated ever had a serious reaction to the influenza vaccine? YES NO
4. Does the person to be vaccinated have an allergy to eggs or other components of the influenza vaccine? YES NO

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## OFFICE USE ONLY

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|---|---|---|---|---|---|---|---|
| **Influenza-*Quad HiDose*** ***Preservative Free*** | | RT LT | Deltoid Vastus Lat | IM | 08/06/2021 | | Exp 6/30/2024 |
| **Influenza-*Quad Blok*** ***Preservative Free*** | | RT LT | Deltoid Vastus Lat | IM | 08/06/2021 | | Exp 6/30/2024 |
| **Influenza-Quad** ***Preservative Free*** | | RT LT | Deltoid Vastus Lat | IM | 08/06/2021 | | Exp 6/30/2024 |
| **Other** | | RT LT | Deltoid Vastus Lat | IM | | | |

*****FOR OFFICE USE ONLY*****

| PATIENT ELIGIBILITY | | | | | | |
|---|---|---|---|---|---|---|
| __T19-MED | __No health insurance | __Native Am/Alaska Native | __Underinsured* | __Underserved** | __ T21-SCHIP | __Fully Insured |

X_____ X_____

Signature and Title of Vaccine Administrator Date