



VFC ELIGIBILITY (FOR OFFICE USE ONLY)

Form with checkboxes for Title 19, UNinsured, NA/AN, Title 21, UNDERinsured, and Not VFC Eligible.

PATIENT INFORMATION

Patient information form including fields for Name, SSN, Birth Date, Age, Sex, Race, Ethnicity, Address, City, State, ZIP Code, Cell Phone No., Home Phone No., and Preferred Language.

IN CASE OF EMERGENCY

Emergency contact form with fields for Name of Emergency Contact, Relationship to Patient, Phone No., and Additional Phone No.

INSURANCE INFORMATION

(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Insurance information form including coverage status, primary insurance details, and subscriber information.

IMMUNIZATION SCREENING QUESTIONNAIRE

Immunization screening questionnaire with 14 numbered questions regarding child's health, allergies, and medical history.

VACCINE CONSENT

Consent statement: I have been offered a copy of the Vaccine Information Statement(s) (VIS) and/or Emergency Use Authorization (EUA) Fact Sheet for the vaccine checked below. I have read, had explained to me, and thusly understand the information. I understand and am aware the vaccine recipient is advised to wait for 15 to 30 minutes post-vaccination for monitoring. I ask that the vaccine checked below be given to me or to the person named above for whom I am authorized to make this request. I consent to the inclusion of this immunization data in the Kansas Immunization Registry for myself or on behalf of the person named above. If I am not the child's parent, I attest that: 1) I may consent to immunizations for this child. 2) I not been denied permission to seek vaccinations for the child. 3) The child's parent(s) are not reasonably available to be with the child at today's appointment.

Vaccine consent checkboxes for COVID-19, DTaP/Hib/IPV (Pentacel), Hep A, HPV, Men Quad, PCV13/15, Rotavirus, Varicella, DTaP, DTaP/IPV/HepB (Pediarix), Hep B, Influenza, MMR, PPSV23, RSV, Other, DTaP/IPV, DTaP/IPV/HepB/Hib (Vaxelis), Hib, Men B, MMR-V, Polio/IPV, Tdap, and Other.

Signature of Patient or Legal Parent/Guardian and Date fields.



BILLING

Riley County Health Department
2030 Tecumseh Rd
Manhattan, Kansas 66502
Phone: 785-776-4779
Fax: 785-565-6566
www.rileycountyks.gov/health

Universal Consent Form

By my signature below, I authorize the Riley County Health Department to bill any of the medical payers as indicated and provide the necessary information to process claims. I authorize payment of medical benefits to the Riley County Health Department for services rendered, and I understand I will be responsible for payment of charges deemed "uncovered" by my health insurance. This constitutes advance notice to you, the beneficiary, that if all program requirements are met by the Riley County Health Department and payment is not made by KanCare or your Health Insurance, you may be responsible for the charges. You may also be responsible for charged if you fail to inform the Health Department of Insurance coverage in a timely manner. The undersigned has read the above authorization and understands the same. I certify that the information provided is true and correct to the best of my knowledge for myself or the person named above for whom I am parent or legal guardian and for whom I am authorized to make medical decisions.

If immunizations are not covered by your health insurance, these items are required to comply with federal regulations and to receive services through the Vaccine For Children program: a written statement or explanation of benefits claim from your Health insurance company stating immunizations are not covered. If we do not have a written statement prior to services, the patient will be responsible for any portion that insurance will not cover. I consent to include vaccines given as immunization data in the Kansas Immunization Registry for myself or the person named above for whom I am parent or legal guardian and for whom I am authorized to make medical decisions.

It is your responsibility to verify that Riley County Health Department is an in-network provider for your insurance company. Charges will be the full price if Riley County is deemed a non-network provider after services are provided.

PRIVACY PRACTICES

All records of services rendered are considered confidential. I acknowledge that I have been offered a copy of the Riley County Health Department's Notice of Privacy Practices with the effective date of April 2019.

LABS / IMMUNIZATIONS

I have received information about the TB skin test and/or blood lead testing. I had a chance to ask questions, which were answered to my satisfaction. If I have received a TB skin test, I agree to return in 48-72 hours to have the test read. I understand the risks and benefits of these services and request the test(s) be given to me or the person named above for whom I am parent or legal guardian and for whom I am authorized to make medical decisions.

I have been advised to wait for 15 minutes after vaccination at Riley County Health Department or outreach location.

DATA APPLICATION AND INTEGRATION SOLUTION FOR THE EARLY YEARS (DAISEY)

As part of the Kansas Department of Health and Environment Family Health Comprehensive System, we will enter your data collected within your family planning visits in an electronic system, Data Application and Integration Solution for the Early Years (DAISEY). The system is designed to keep your information secure. We will only use your information to track, evaluate, and improve the reproductive health services you receive from us.

Information that will be entered into the system includes:

- Individually Identifiable Health Information (Ex: name, gender, date of birth).
- Information about services you receive (Ex: health screening, education, home visits).
- Information about assessments you receive as part of a service (Ex: answers to questions about housing needs, tobacco use, prenatal care).

This notice is effective on the date below. Your signature acknowledges receipt of this notice but is not required. This notice will remain in effect until the organization destroys your information. You may ask to see your information at any time.

INTEGRATED REFERRAL AND INTAKE SYSTEM (IRIS)

By signing below, I agree that my family/household members' information can be shared in IRIS with other service providers in my community's referral network who will also secure my information. All information is confidential and will only be shared for its intended purpose of providing wanted services to yourself and/or your family.

SIGNATURE _____

DATE _____

NURSE DOCUMENTATION (FOR NURSE USE)

VACCINE	EXT	SITE	ROUTE	VIS Date	MANUFACTURER, LOT #, EXPIRATION DATE
DTaP / Td / Tdap	RT LT	Deltoid Vastus Lat	IM	Documented In EHR/ KSWebIZ	
DTaP/IPV (Kinrix/Quadacel)	RT LT	Deltoid Vastus Lat	IM	Documented In EHR/ KSWebIZ	
DTaP/HepB/IPV (Pediarix)	RT LT	Deltoid Vastus Lat	IM	Documented In EHR/ KSWebIZ	
DTaP/Hib/IPV (Pentacel)	RT LT	Deltoid Vastus Lat	IM	Documented In EHR/ KSWebIZ	
DTaP/IPV/HepB/Hib (Vaxelis)	RT LT	Deltoid Vastus Lat	IM	Documented In EHR/ KSWebIZ	
Hepatitis A	RT LT	Deltoid Vastus Lat	IM	Documented In EHR/ KSWebIZ	
Hepatitis B	RT LT	Deltoid Vastus Lat	IM	Documented In EHR/ KSWebIZ	
Hib	RT LT	Deltoid Vastus Lat	IM	Documented In EHR/ KSWebIZ	
HPV (Gardasil 9)	RT LT	Deltoid	IM	Documented In EHR/ KSWebIZ	
MCV4/MPSV4 (Menveo/MenQuadfi)	RT LT	Deltoid	IM	Documented In EHR/ KSWebIZ	
Meningococcal B (Trumenba/Bexsero)	RT LT	Deltoid	IM	Documented In EHR/ KSWebIZ	
MMR	RT LT	Upper Arm Thigh	SC	Documented In EHR/ KSWebIZ	
MMRV (ProQuad)	RT LT	Upper Arm Thigh	SC	Documented In EHR/ KSWebIZ	
PCV13/15 Prenar 13 Vaxneuvance 15	RT LT	Deltoid Vastus Lat	IM	Documented In EHR/ KSWebIZ	
Polio/IPV	RT LT	Upper Arm Deltoid	IM SC	Documented In EHR/ KSWebIZ	Dosage (MDV): 0.5mL
PPV23 Pneumovax 23	RT LT	Deltoid Vastus Lat	IM	Documented In EHR/ KSWebIZ	
Rotavirus (Rotarix/RotaTeq)	PO	By Mouth	Oral	Documented In EHR/ KSWebIZ	
Varicella	RT LT	Upper Arm Thigh	SC	Documented In EHR/ KSWebIZ	

VACCINE ADMINISTRATOR (APPLICABLE TO ENTIRE SHEET)

Signature: _____

Date: _____

NURSE DOCUMENTATION (FOR NURSE USE)

VACCINE	EXT	SITE	ROUTE	VIS Date	MANUFACTURER, LOT #, EXPIRATION DATE
COVID-19, Monovalent Moderna 6mo-11y Moderna 12+	RT LT	Deltoid Vastus Lat	IM	Documented In EHR/ KSWebIZ	Circle Dosage (MDV): 0.25 mL 0.5 mL
Influenza (Flu), Standard dose, Egg-based Fluarix Fluzone	RT LT	Deltoid Vastus Lat	IM	Documented In EHR/ KSWebIZ	Circle Dosage (MDV): 0.25 mL 0.5 mL
Influenza (Flu), Recombinant HA Flublok	RT LT	Deltoid Vastus Lat	IM	Documented In EHR/ KSWebIZ	
JYNNEOS	RT LT	Brachium Thigh	SC	Documented In EHR/ KSWebIZ	Circle Dosage (MDV): 0.5 mL
Beyfortus	RT LT	Vastus Lat Deltoid	IM	Documented In EHR/ KSWebIZ	Circle Dosage (MDV): 0.5 mL 1 mL 2 mL

VACCINE ADMINISTRATOR (APPLICABLE TO ENTIRE SHEET)

Signature: _____

Date: _____