Riley County Health Department

VACCINE REGISTRATION FORM (0-18 years of age)

VFC ELIGIBILITY (FOR OFFICE USE ONLY)		
❑ Title 19	❑ UNinsured	❑ NA/AN
❑ Title 21	❑ UNDERinsured	❑ Not VFC Eligible

PATIENT INFORMATION

Patient's First Name | Middle Name | Last Name

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name(s))	Birth Date / /	Age	Sex ❑ M ❑ F

Race: ❑ Asian/Pacific Islander/Other ❑ Black or African American ❑ Caucasian or White ❑ Native American/Alaska Native ❑ Hawaiian ❑ Unknown or Other

Ethnicity: Hispanic/Latino?: ❑ Yes ❑ No

Current Address	City	State	ZIP Code

Cell Phone No. (text appointment reminders) ( )	Home Phone No. ( )	Preferred Language

IN CASE OF EMERGENCY

Name of Emergency Contact	Relationship to Patient	Phone No. ( )	Additional Phone No. ( )

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Is this patient covered by insurance? ❑ Yes ❑ No | Are immunizations covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance (Blue Cross, Aetna, Sunflower, etc.):

Subscriber's Name	Subscriber's Birth Date / /	Policy #	Group #

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other

IMMUNIZATION SCREENING QUESTIONNAIRE

Question	Answer
1. Is the child currently sick or experiencing a high fever? If yes, please explain: ______	☐ Yes ☐ No
2. Does the child have allergies to medications, food, or a vaccine component, or latex? If yes, please list: ______	☐ Yes ☐ No
3. Has the child felt dizzy or faint before, during, or after a shot?	☐ Yes ☐ No
4. Has the child had a serious reaction to a vaccine in the past? If yes, please explain: ______	☐ Yes ☐ No
5. Does the child have a long-term health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Is he/she on long-term aspirin therapy? If yes, please explain: ______	☐ Yes ☐ No
6. **For babies:** Has the child ever had intussusception (intestine issue)?	☐ Yes ☐ No
7. Has the child, a sibling, or a parent had a seizure? Has the child had brain or other nervous system problems? If yes, please explain: ______	☐ Yes ☐ No
8. Has the child to be vaccinated ever had Guillain-Barré syndrome (neurological disorder)?	☐ Yes ☐ No
9. Does the child have an immune system problem such as cancer, leukemia, HIV/AIDS? If yes, please explain: ______	☐ Yes ☐ No
10. Does the child have a parent, brother, or sister with an immune system problem?	☐ Yes ☐ No
11. In the past 6 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments? If yes, please explain: ______	☐ Yes ☐ No
12. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? If yes, please explain: ______	☐ Yes ☐ No
13. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐ Yes ☐ No
14. Has the child received vaccinations in the past 4 weeks? If yes, please list vaccines: ______	☐ Yes ☐ No

VACCINE CONSENT

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.

❑ 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	❑ Other ______

Signature of Patient or Legal Parent/Guardian: | Date:

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. I had a chance to ask questions which were answered to my satisfaction. I agree to return in 48-72 hours to have the test read. I understand the risks and benefits of the TB skin test and request the test 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/Quadracel)	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 Prevnar 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: