Riley County Health Department
VACCINE REGISTRATION FORM for Adults (19 years of age and older)

VFC ELIGIBILITY (OFFICE USE ONLY)	
❑ Not VFC Eligible – Uninsured Adult (Merck?)	❑ 317 Eligible (Tdap/FLU/COVID-19)
❑ Not VFC Eligible – Out of Pocket (requested)	❑ Not VFC Eligible – Fully Insured

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	Policy #	Group #
	/ /		

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

IMMUNIZATION SCREENING QUESTIONNAIRE

	Question	
1.	Are you sick or experiencing a fever today? If yes, please explain: ______	☐ Yes ☐ No
2.	Do you have allergies to medications, food, a vaccine component, or latex? If yes, please list: ______	☐ Yes ☐ No
3.	Have you ever had a serious reaction after receiving a vaccination? If yes, please explain: ______	☐ Yes ☐ No
4.	Do you have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy? If yes, please explain: ______	☐ Yes ☐ No
5.	Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐ Yes ☐ No
6.	Do you have a parent, brother, or sister with an immune system problem?	☐ Yes ☐ No
7.	In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments? If yes, please explain: ______	☐ Yes ☐ No
8.	Have you had a seizure or a brain or other nervous system problem? Have you ever had Guillain-Barré syndrome?	☐ Yes ☐ No
9.	During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? If yes, please explain: ______	☐ Yes ☐ No
10.	Are you a healthcare worker?	☐ Yes ☐ No
11.	Are you a laboratory worker that may be routinely exposed to isolates of Neisseria meningitidis, or specimens potentially containing the hepatitis A or hepatitis B virus?	☐ Yes ☐ No
12.	**For women:** Are you pregnant or is there a chance you could become pregnant during the next month? Please circle.	☐ Yes ☐ No
13.	Have you received any vaccinations in the past 4 weeks? If yes, please explain: ______	☐ Yes ☐ No
14.	Are you a smoker?	☐ Yes ☐ No
15.	Are you currently or will you soon be living in a residence hall or a building that houses a large number of people?	☐ Yes ☐ No
16.	Do you have a history of myocarditis or pericarditis?	☐ Yes ☐ No
17.	Do you have a history of heparin-induced thrombocytopenia (HIT)?	☐ 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 understand the information. I understand and am aware I am 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.

❑ COVID-19	❑ Hep A/B	❑ Influenza	❑ Men ACWY	❑ Prevnar 13/15	❑ Polio/IPV	❑ Tdap
❑ Hepatitis A	❑ Hib	Japanese	❑ Men B	❑ Prevnar 20	❑ Rabies, pre-exposure	❑ Varicella
❑ Hepatitis B	❑ HPV	❑ Encephalitis	❑ MMR	❑ PPSV23	❑ Shingles	❑ 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
Hepatitis A	RT LT	Deltoid	IM	Documented In EHR/ KSWebIZ	
Hepatitis B	RT LT	Deltoid	IM	Documented In EHR/ KSWebIZ	
HepA/HepB (Twinrix)	RT LT	Deltoid	IM	Documented In EHR/ KSWebIZ	
Hib	RT LT	Deltoid	IM	Documented In EHR/ KSWebIZ	
HPV (Gardasil 9)	RT LT	Deltoid	IM	Documented In EHR/ KSWebIZ	
Japanese Encephalitis (2 months and older)	RT LT	Deltoid	IM	Documented In EHR/ KSWebIZ	
Meningococcal B (Bexsero/Trumenba)	RT LT	Deltoid	IM	Documented In EHR/ KSWebIZ	
Meningococcal Quad (Menveo/MenQuadfi)	RT LT	Deltoid	IM	Documented In EHR/ KSWebIZ	
MMR	RT LT	Upper Arm	SC	Documented In EHR/ KSWebIZ	
PCV 13, 15, 20 Prevnar 13 Vaxneuvance 15 Prevnar 20	RT LT	Deltoid	IM	Documented In EHR/ KSWebIZ	
PPV23 Pneumovax 23	RT LT	Deltoid	IM	Documented In EHR/ KSWebIZ	
Polio/IPV	RT LT	Upper Arm Deltoid	IM SC	Documented In EHR/ KSWebIZ	**Dosage (MDV): 0.5mL**
Rabies (Pre-Exposure)	RT LT	Deltoid	IM	Documented In EHR/ KSWebIZ	
Shingrix	RT LT	Deltoid	IM	Documented In EHR/ KSWebIZ	
Td / Tdap	RT LT	Deltoid	IM	Documented In EHR/ KSWebIZ	
Varicella	RT LT	Upper Arm	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 Pfizer 12+ Moderna 18+ Janssen Novavax	RT LT	Deltoid	IM	Documented In EHR/ KSWebIZ	**Circle Dosage (MDV):** 0.3mL 0.5mL
COVID-19, Bivalent Pfizer 12+ Booster Moderna 18+ Booster	RT LT	Deltoid	IM	Documented In EHR/ KSWebIZ	**Circle Dosage (MDV):** 0.3mL 0.5mL
Influenza (Flu), Standard dose, Egg-based Fluarix Fluzone	RT LT	Deltoid	IM	Documented In EHR/ KSWebIZ	**Circle Dosage (MDV):** 0.5mL
Influenza (Flu), High-dose, Egg-based Fluzone High-Dose	RT LT	Deltoid	IM	Documented In EHR/ KSWebIZ	
Influenza (Flu), Recombinant HA Flublok	RT LT	Deltoid	IM	Documented In EHR/ KSWebIZ	
JYNNEOS	RT LT	Antebrachium Brachium Thigh	ID SC	Documented In EHR/ KSWebIZ	**Circle Dosage (MDV):** 0.1mL 0.5mL

VACCINE ADMINISTRATOR (APPLICABLE TO ENTIRE SHEET)

Signature: Date: