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STUDENT HEALTH CENTER

VACCINE DOCUMENTATION/CONSENT FORM

PATIENT INFORMATION				
Last Name:	**First Name:**	**Phone Number:**	**Age:**	**Birth date:**
Street Address:	**City:**	**State:**	**Zip Code:**	

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.

☐ Tdap ☐ Hepatitis A ☐ Hepatitis B ☐ HPV/Gardasil 9 ☐ Influenza ☐ Meningococcal

☐ Varicella ☐ Other_____

_____ _____
Signature of Patient or Parent/Guardian Date

IMMUNIZATION SCREENING QUESTIONNAIRE	
1. Are you currently sick or experiencing a high fever?	☐ yes ☐ no
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐ yes ☐ no
3. Have you had a serious reaction to a vaccine in the past?	☐ yes ☐ no
4. Have you had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	☐ yes ☐ no
5. Have you, or your sibling or parent had a seizure; have you had brain or other nervous system problems?	☐ yes ☐ no
6. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐ yes ☐ no
7. Do you have close, regular contact with someone who has a weakened immune system?	☐ yes ☐ no
8. In the past 3 months, have you taken medications that weaken the immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?	☐ yes ☐ no
9. In the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐ yes ☐ no
10. Are you pregnant or is there a chance you could become pregnant during the next month?	☐ yes ☐ no
11. Have you received vaccinations in the past 4 weeks?	☐ yes ☐ no

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Patient Name: _____ DOB: _____

PROVIDER INFORMATION	
Name of Vaccine Provider: ☐ Traci Ditter ☐ _____ ☐ Amanda McCord	Fort Hays State University Student Health Center 600 Park St. - LL045M U Hays, KS 67601 (785) 628-4293

FOR CLINICAL USE ONLY

VACCINE	DOSE	EXT	SITE	ROUTE	VIS DATE	MANUFACTURER LOT #	EXP DATE
Tdap	0.5 mL 1 2 3 4 5 6	RT LT	☐ Deltoid ☐ Vastus Lat	IM			
Hep A	.05 mL 1.0 mL 1 2	RT LT	☐ Deltoid ☐ Vastus Lat	IM			
Hep B	.05 mL 1.0 mL 1 2 3	RT LT	☐ Deltoid ☐ Vastus Lat	IM			
HPV	0.5 mL 1 2 3	RT LT	☐ Deltoid	IM			
Influenza LAIV4 IIV3 IIV4	0.1mL 0.2mL 0.25mL 0.50mL 1 2	RT LT	☐ Upper Arm ☐ Deltoid ☐ Vastus Lat	Intradermal Intranasal IM			
MCV4	0.5 mL 1 2	RT LT	☐ Deltoid	IM			
Varicella	0.5 mL 1 2	RT LT	☐ Upper Arm ☐ Thigh	SC			
Other							

Provider Signature: _____ Date: _____