Reno County Health Department
Vaccine Documentation Form

Place Label Here

Adult

		IAP
Self Pay	Number In Family	Previous Balance
3rd Party Payor		
Insurance Policy #		
Medicaid Policy #		
Medicare Policy #		

*****Client Information*****

Last Name	First Name	Middle Name		Physician
Birth Date	Age	Previous Names Used at Health Dept.	Male	Female
Address	City	State / Zip		Phone Number

Race: White Black/African American American Indian/Alaska Native Asian Hawaiian / Pacific Islander

Hispanic or Latino? Yes No If yes, Please Choose: Mexican Cuban Puerto Rican Central/South American

RENO COUNTY HEALTH DEPARTMENT CONSENT AND VACCINE SCREENING QUESTIONNAIRE

_____ Yes _____ No Are you sick today or experiencing a high fever?

_____ Yes _____ No Do you have allergies to medications, food, latex, or a vaccine component?

_____ Yes _____ No Have you had a serious reaction to a vaccine in the past?

____ Yes ____ No Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease , metabolic disease (e.g. diabetes), anemia or other blood disorders.

_____ Yes _____ No Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?

_____ Yes _____ No Have you had a seizure or other nervous system problem?

____ Yes ____ No Do you have close, regular contact with someone with a weakened immune system?

____ Yes ____ No In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, antiviral medications, anticancer drugs, or had radiation treatments?

____ Yes ____ No During 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 For women: Are you pregnant or is there a chance you could become pregnant during the next month?

____ Yes ____ No Have you received vaccinations in the past 4 weeks?

Contraindications: General for all vaccines:

1. Anaphylactic reaction to a vaccine contraindicates further doses of that vaccine.
2. Anaphylactic reaction to a constituent contraindicates the use of vaccine containing that substance.
3. Moderate or severe illness with or without fever.

I acknowledge that I have been offered a copy of the Reno County Health Department's Notice of Privacy Practices.

I authorize the release of the medical or billing information necessary to process claims for insurance providers including Medicare. I have been informed that if I provide a copy of my Health Insurance or Medicare card, a claim for service will be submitted to my insurance provider. If an insurance claim is denied, services will be billed to me at full charge unless the Income Documentation section has been completed and qualifies me for a reduced rate.

I request payment of insurance benefits to the Reno County Health Department.

I consent to the inclusion of immunization data in the Kansas Immunization Registry.

I have been given a copy and have read, or have had explained to me, the information in the Vaccine Information Statement (VIS) and ask that the vaccine(s) be given to me or to the person named for who I am authorized to make this request.

NOTE: According to Kansas Statute 65-531

Information and records which pertain to the immunization status of persons against childhood diseases as required by K.S.A. 65-508 and 65-519 may be disclosed and exchanged without a parent or guardian's written release authorizing such disclosure to those who need such information to assure compliance with state statutes or to achieve age appropriate immunization status for children. See State Statute 65-531 for complete description.

_____ _____

Signature of Client, Parent or Guardian Date

_____ _____

Signature of Health Care Worker Date

Name

Vaccine	Dose	EXT	Site	Route	Manufacturer Lot #	EXP Date	CPT Code
HAA (Hepatitis A)	1.0ml	Right Left	Deltoid	IM			90632
HBV (Hepatitis B)	1.0ml	Right Left	Deltoid	IM			90746
HPVP 9 (Human Papilloma Virus)	0.5ml	Right Left	Deltoid	IM			90651
MMP (Measles/Mumps/Rubella)	0.5ml	Right Left	Upper Arm	Sub - Q			90707
MNP (Meningococcal)	0.5ml	Right Left	Deltoid	IM			90734
MTP (Meningococcal) (Trumenba)	0.5ml	Right Left	Deltoid	IM			90621
MBP (Meningococcal) (Bexsero)	0.5ml	Right Left	Deltoid	IM			90620
PNU (Pneumonia)	0.5ml	Right Left	Deltoid Upper Arm	IM - Sub-Q			90732
IPP (Polio)	0.5ml	Right Left	Deltoid Upper Arm	IM - Sub-Q			90713
PRR (Pre-Exposure Rabies)	1.0ml	Right Left	Deltoid	IM			90675
TAP (Tetanus/Diphtheria/Pertussis)	0.5ml	Right Left	Deltoid	IM			90715
TDP (Tetanus/Diphtheria)	0.5ml	Right Left	Deltoid	IM			90714
TYP TYO (Typhoid)	0.5ml	Right Left	Deltoid	IM - Oral			90691/90690
VAR (Varicella)	0.5ml	Right Left	Upper Arm	Sub-Q			90716
YFV (Yellow Fever)	0.5ml	Right Left	Upper Arm	Sub-Q			90717
ZOS (Zoster)	0.65ml	Right Left	Upper Arm	Sub-Q			90736
SHING (Shingrix)	0.5ml	Right Left	Deltoid	IM			90750
QFLU (Influenza)	0.5ml	Right Left	Deltoid	IM			90686
90662 (Influenza - High Dose)	0.5ml	Right Left	Deltoid	IM			90662
90682 (Flublok)	0.5ml	Right Left	Deltoid	IM			90682
QMST (Flu Mist))	0.2ml	Right Left	Intranasal	Intranasal			90672

	QTY
CER - International Travel Certificate	
99401 - Travel Consultation < 30 minutes	
99402 - Travel Consultation > 30 minutes	

	QTY
90471	
90472	
90473	
90474	

	QTY
G0008 (Flu) Medicare	
G0009 (PNU) Medicare	

Provider Signature

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Date Vaccinated

Check In