Sherman County Health Department

1622 Broadway, Goodland, KS 67735

SEASONAL VACCINE DOCUMENTATION / CONSENT FORM

I have been offered a copy of the Vaccine Information Statement(s), whether accepted or not, for the vaccine indicated below. I have read or had explained to me the information in the VIS(s), including the possible adverse reactions, the components of the vaccine, the possible risks, and what to do after the vaccination(s). I ask that the vaccine checked below be given to me or to the person named below 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 below.

I acknowledge that I have been provided the Health Department's Notice of Privacy Practices with the effective date of August 30, 2013.

X		
Signature of Patient/Parent or Legal Guardian	**Relationship (if parent/legal guardian)**	**Date**

PATIENT INFORMATION

Patient's Last Name	Patient's First Name	Date of Birth	Age	Gender
				____ Male _____ Female

Street Address/Mailing Address	City	State	Zip Code	Phone Number

INSURANCE INFORMATION

I would like Sherman County Health Department to bill:

☐ Medicare Plan B	☐ BC/BS	☐ KanCare	☐ Other	Insurance ID# ______________________________________

Name as it appears on Insurance Card ____ DOB of Card Holder: ________________

VFC Eligibility: ____ Yes ____ No ____ 317

HEALTH SCHREENING QUESTIONS

1	Is the person to be vaccinated sick today (temperature over 100)?	____ Yes	____ No
2	Does the person to be vaccinated today have an allergy to a component of the vaccine?	____ Yes	____ No
3	Has the person to be vaccinated ever had a serious reaction to the influenza vaccine in the past?	____ Yes	____ No
4	Has the person to be vaccinated ever had Guillian-Barre syndrome?	____ Yes	____ No

CLINICAL USE ONLY

Quadrivalent 90686 90471/G0008	0.5ml	RT LT	Del Vas Lat	IM	VIS 08/06/2021	Manufacturer: GSK Sonofi	***Place labels here***:

Today's Charge:	$ ________________	**Self-pay:**	____ Cash	_____ Check # ________________	**Contract Pay:**	_____ Yes _____ No	Company Name:

Signature and Title of Vaccine Administrator / Date Given