Place Label Here
Pediatric - SLV

Reno County Health Department
Vaccine Documentation Form

Off Site
SLV

Amerigroup ☐ United Healthcare ☐
Sunflower ☐

****PRIVATE-VACCINE****

Title-19 ☐ CHIP-21 ☐

NO INSURANCE COVERAGE
****VFC VACCINE****

Commercial Ins: ☐

TTP-Third Party Pay: ☐

No Insurance ☐ American Indian ☐
Insufficient ☐ Alaska Native ☐

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

Last Name		Name	MI	Responsible Party	
Date of Birth	Age	Sex	SSN	Responsible Party SSN	Responsible Party Date of Birth:
Address		Phone		Responsible Party Phone	
City	State	Zip		Physician's Phone	Physician

Insurance Policy Number

in Family:

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

Hispanic or Latino ☐ YES ☐ NO Choose One: ☐ Mexican ☐ Cuban ☐ Puerto Rican ☐ Central/South American

Immunization Screening Questionnaire

1. Is the person to be vaccinated currently sick or experiencing a high fever?	☐ Yes ☐ No
2. Does the child have allergies to medications, food, latex, or a vaccine component?	☐ Yes ☐ No
3. Has the child had a serious reaction to a vaccine in the past?	☐ Yes ☐ No
4. Has the child had a health problem with the lungs, heart, kidneys, or metabolic disease (e.g. diabetes, asthma, or a blood disorder? Is he/she on a long-term aspirin therapy?	☐ Yes ☐ No
5. If the child to be vaccinated is between the ages of 2 and 4 years, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐ Yes ☐ No
6. If your child is a baby, have you ever been told he or she has had intussusception?	☐ Yes ☐ No
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐ Yes ☐ No
8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐ Yes ☐ No
9. Does the child to be vaccinated have close, regular contact with someone with a weakened immune system?	☐ Yes ☐ No
10. In the past 3 months, has the child taken medications that weaken their immune system, such as cortisone, prednisone, other steroids, antiviral medications, anticancer drugs, or had radiation treatments.	☐ Yes ☐ No
11. Has the child to be vaccinated received blood, plasma, or immune globulin in the past twelve months?	☐ Yes ☐ No
12. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐ Yes ☐ No
13. Has the child received vaccinations in the past 4 weeks?	☐ Yes ☐ No

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

* I acknowledge that I have been offered a copy of the Reno County Health Department's Notice of Privacy Practices with the effective date of 09/25/2013.

* I authorize the release of the medical or billing information necessary to process claims for insurance providers including Medicare.

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.

Client's Name _____ Date _____

Signature of Client/Parent/Guardian _____ Date _____

Signature of Health Care Worker _____ Date _____

Name _____ School _____ VFC Free Private

VFC / CHIP	Private	Dose	EXT	Site	Route	Manufacturer Lot #	Exp Date	DX Code
DTAV (DTaP)	DAP (DTaP)	0.5ml	Right Left	Deltoid Vastus Lat.	IM			Z23
HAV (Hepatitis A)	HAC (Hepatitis A)	0.5ml	Right Left	Deltoid Vastus Lat.	IM			Z23
HBVV (HIB)	HIBP (HIB)	0.5ml	Right Left	Deltoid Vastus Lat.	IM			Z23
HPVV9 (Human Papilloma Virus-9)	HPVP9 (Human Papilloma Virus-9)	0.5ml	Right Left	Deltoid Vastus Lat.	IM			Z23
VHB (Hepatitis B)	HBC (Hepatitis B)	0.5ml	Right Left	Deltoid Vastus Lat.	IM			Z23
PVV (Polio)	IPP (Polio)	0.5ml	Right Left	Deltoid Vastus Lat. Upper Arm Thigh	IM - Sub-Q			Z23
KNXV (DTaP - IPV)	KNXP (DTaP - IPV)	0.5ml	Right Left	Deltoid Vastus Lat.	IM			Z23
MMRV (Measles/Mumps/Rubella)	MMP (Measles/Mumps/Rubella)	0.5ml	Right Left	Upper Arm Thigh	Sub - Q			Z23
MNV (Meningococcal)	MNP (Meningococcal)	0.5ml	Right Left	Deltoid Vastus Lat.	IM			Z23
MTV (Meningococcal) (Trumenba)	MTP (Meningococcal) (Trumenba)	0.5ml	Right Left	Deltoid Vastus Lat.	IM			Z23
MBV (Meningococcal) (Bexsero)	MBP (Meningococcal) (Bexsero)	0.5ml	Right Left	Deltoid Vastus Lat.	IM			Z23
DPHV (DTaP,Polio,Hep B)	PDP (DTaP,Polio,Hep B)	0.5ml	Right Left	Deltoid Vastus Lat.	IM			Z23
PCV13 (PCV 13)	PCVP (PCV 13)	0.5ml	Right Left	Deltoid Vastus Lat.	IM			Z23
VPNU (Pneumonia)	PNU (Pneumonia)	0.5ml	Right Left	Deltoid Vastus Lat. Upper Arm Thigh	IM - Sub-Q			Z23
RVV (Rotovirus)	RVP (Rotovirus)	2.0ml		Oral	Oral			Z23
TDPV (Tetanus/Diphtheria/Pertussis)	TAP (Tetanus/Diphtheria/Pertussis)	0.5ml	Right Left	Deltoid Vastus Lat.	IM			Z23
TDV (Tet/Dip)	TDP (Tet/Dip)	0.5ml	Right Left	Deltoid Vastus Lat.	IM			Z23
VARV (Varicella)	VAR (Varicella)	0.5ml	Right Left	Upper Arm Thigh	Sub-Q			Z23
VQINF, VQFLU (Quadrivalent)	QINF QFLU (Quadrivalent)	0.25ml 0.5ml	Right Left	Deltoid Vastus Lat.	IM			Z23

Travel Codes

☐ CER ☐ 99401 ☐ 99402

Administration Codes

☐ 90471 ☐ 90472 ☐ 90473 ☐ 90474

$ _____
Previous Balance

_____
Next Appt:

_____
Provider Signature

F:\Masters\Encounters\SLV Imm Enc\Pediatric:,12/15,02/16,08/16

_____
Date Vaccinated

Check In Time

_____
Minutes

Check Out Time