Sherman County Health Department

1622 Broadway, Goodland, KS 67735
VACCINE DOCUMENTATION/CONSENT FORM

I have been offered a copy of the Vaccine Information Statement(s), whether accepted or not, for the vaccine checked 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.

☐ **COVID-19 Vaccine** **Dose (circle):** 1 2 3

X _____ X _____

Signature of Patient/Parent or Guardian ***Date***

PATIENT INFORMATION

Patient's Last Name:	Patient's First Name:	Birth Date:	Age:	Phone Number:

Street Address/Mailing Address:	City:	County:	State:	Zip Code:

Ethnicity: Hispanic or Latino
____ Yes ____ No

Gender
____ Male ____ Female

Physician's Name_____

Race: (Select one or more)
____ Caucasian/Mexican/Puerto Rican
____ Black or African American
____ American Indian or Alaska Native
____ Native Hawaiian/or Other Pacific Islander
____ Asian
____ Unknown/Not Reported

IMMUNIZATION SCREENING QUESTIONNAIRE

1.	Is the person to be vaccinated currently sick or experiencing a high fever?	__yes __no
2.	Does the patient have allergies to medications, food, a vaccine component, or latex?	__yes __no
3.	Has the patient had a serious reaction to a vaccine in the past?	__yes __no
4.	Has the patient 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.	Has the patient, a sibling, or a parent had a seizure; has the child had brain or other immune system problems?	__yes __no
6.	Does the patient have cancer, leukemia, HIV/AIDS, or any other immune system problem?	__yes __no
7.	In the past 3 months, has the patient taken medications that weaken their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?	__yes __no
8.	In the past year, has the patient received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	__yes __no
9.	Is the patient pregnant or is there a chance she could become pregnant during the next month?	__yes __no
10.	Has the patient received vaccinations in the past 4 weeks?	__yes __no

For OFFICE USE only: **Patient WebIZ#**

VACCINE	*DOSE*	*EXT*	*SITE*	*ROUTE*	*MANUFACTURER LOT #*	*EXP DATE*
COVID-19	0.5 ml. 0.3 ml 1 2	RT LT	Deltoid Vastus Lat	IM	Pfizer / Moderna / Janssen	
				VIS	9/22/2021	8/27/2021	8/27/2021

Signature and Title of Vaccine Administrator / Date Given