GENERAL VACCINE CONSENT FORM

Patient's Name: _____ **Patient's Date of Birth:** _____

IMMUNIZATION SCREENING QUESTIONNAIRE			
1. Has the patient had a fever greater than 101®F within the past 24 hours?	Yes ☐	No ☐	N/A ☐
2. Does the patient have allergies to medications, food, a vaccine component, or latex? If yes, please explain:	Yes ☐	No ☐	N/A ☐
3. Has the patient had a serious reaction to a vaccine in the past?	Yes ☐	No ☐	N/A ☐
4. If the patient is a baby, have you ever been told he or she has had intussusceptions?	Yes ☐	No ☐	N/A ☐
5. Has the patient had a seizure, encephalopathy, or Guillain-Barré syndrome; has the child had brain or other nervous system problems?	Yes ☐	No ☐	N/A ☐
6. Does the patient have cancer, leukemia, HIV/AIDS, or any other immune system problem?	Yes ☐	No ☐	N/A ☐
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 ☐	N/A ☐
8. In the past year, has the patient received a transfusion of blood or blood products or been given immune (gamma) globulin?	Yes ☐	No ☐	N/A ☐
9. Is the patient pregnant or is there a chance she could become pregnant during the next month?	Yes ☐	No ☐	N/A ☐
10. Has the patient received vaccinations in the past 4 weeks?	Yes ☐	No ☐	N/A ☐
INFLUENZA ONLY			
11. If under the age of 9, has the patient received a flu vaccine before?	Yes ☐	No ☐	N/A ☐

☐ DT ☐ DTaP ☐ Tdap ☐ Td ☐ HepA ☐ HepB ☐ Hib ☐ Varicella

☐ Meningococcal ACY&W-135 ☐ Meningococcal B ☐ MMR ☐ PCV13 ☐ PCV23 ☐ Polio/IPV

☐ Rotavirus ☐ Influenza Shot ☐ FluMist ☐ HPV4* ☐ HPV9*

I have been offered a copy of the Vaccine Information Statement(s) (VIS) checked above. I have read, had explained to me, and understand the information in the VIS(s). I understand the benefits and risks of all vaccines to be given today. I asked that the vaccine(s) checked above be given to me or to the person named above for whom I am authorized to make this request. I fully release and discharge, Leawood Pediatrics, its affiliates, officers, directors, and employees from any liability related to the administration of these vaccines. I consent to inclusion of this immunization data in the Kansas Immunization Registry for myself or on behalf of the person named above.

****If you are receiving either HPV shot today, we require you to wait 15 minutes after receiving the shot to ensure not reaction.***

Patient/Guardian Signature: _____ Date: _____

If legal guardian, print name: _____

OFFICE USE ONLY

Date booster required (if applicable): _____ **Give card to parent with date

VACCINE	DOSE #	EXT	SITE	ROUTE	LOT #	EXP DATE
		RT LT	Deltoid Vastus Lat Upper Arm Thigh	IM SC Oral		
		RT LT	Deltoid Vastus Lat Upper Arm Thigh	IM SC Oral		
		RT LT	Deltoid Vastus Lat Upper Arm Thigh	IM SC Oral		
		RT LT	Deltoid Vastus Lat Upper Arm Thigh	IM SC Oral		
		RT LT	Deltoid Vastus Lat Upper Arm Thigh	IM SC Oral		
Name & Title of Vaccine Administrator					Date	