VACCINE DOCUMENTATION/CONSENT FORM

I have been offered a copy of the Vaccine Information Statement(s) (VIS) checked below. I have read, had explained to me, and understand the information in the VIS(s). I ask that the vaccine(s) checked below be given to me or to the person named below for whom I am authorized to make this request. I consent to inclusion of this immunization data in the Kansas Immunization Registry for myself or on behalf of the person named below.

Influenza

Signature_____Date_____

Parent/Guardian signature for student/ Patient if Adult

PATIENT INFORMATION				
Patient's Last Name: **Patient's First Name:**		**Phone Number:**	**Age:**	**Birth date:**
Street Address:	**City:**	**County:**	**State:**	**Zip Code:**
Ethnicity: Hispanic or Latino ___ Yes ___ No **Gender** ___ Male ___ Female	**Race:** (Select one or more.) ___ AS-Asian/Pacific Islander/Other ___ BL-Black or African American ___ CA-Caucasian/Mexican/Puerto Rican ___ CH-Chinese ___ FI-Filipino ___ HA-Hawaiian ___ IN-Native American/Alaska Native ___ JA-Japanese ___ NW-Other Non-White ___ UN-Unknown			
Primary Care Physician:	**Street Address:** **City:**	**State:** **Zip:**	**Phone:** **Fax:**	

PATIENT ELIGIBILITY						
__T19-MED	__No health insurance	__Native Am/Alaska Native	__Underinsured*	__Underserved**	__ T21-SCHIP	__Fully Insured

*Underinsured children: insurance does not cover immunizations. Eligible through VFC program if vaccinated at a FQHC, RHC or delegated county health department.
**Underserved (State) children: Are not VFC eligible. May only be vaccinated with KIP vaccines needed at school (K-12) entry at a county health department if enrolled in federal free or reduced-price school lunch program.

1. Has the patient received vaccinations in the past 4 weeks? YES NO
2. Has the person to be vaccinated ever had Guillian-Barre' syndrome? YES NO
3. Has the person to be vaccinated ever had a serious reaction to the influenza vaccine? YES NO
4. Does the person to be vaccinated have an allergy to eggs or other components of the influenza vaccine? YES NO

Insurance Information

Insurance (circle one) KanCare BCBS Other (specify)_____

Insurance # _____ Group Number _____ Insured Name _____

Insured DOB_____ Relationship (circle): Father / Mother / Self

Parent Name (Please Print) _____ Date: _____

***** Please attach copy of insurance card *****

**** If child has no insurance, please complete the following:** Family Size_____ Annual Income $_____

OFFICE USE ONLY

Influenza-*Quad* ***(3yrs and up)*** ***.5 ml*** ***Cpt-90686*** ***Preservative Free***	1 2	RT LT	Deltoid Vastus Lat	IM	08/6/2021		Exp 6/30/2022

Ellsworth County Health Department
1603 Aylward Avenue
Ellsworth, KS 67439
Ph: 785-472-4488 Fax: 785-472-4489
Email: ellscohd@eaglecom.net

Dear Parents of Students in USD 327,

The Ellsworth County Health Department will be having a "Flu Vaccine Day" that will include only the FLU shot. The date of the clinic will be **Wednesday, October 6th** at EES, KMS and EJSHS. If you have a medical card through KanCare (Aetna, Sunflower, or UnitedHealthcare) the immunization vaccines is covered. *Please send a copy of your insurance or medical card*. If you don't have insurance or it does not cover immunizations, your child MAY qualify for Vaccine for Children (VFC) through the State of Kansas (coverage will be determined by Health Department). Please complete the attached form in its entirety. Immunizations will not be given if form is not completed and signed by day of immunization clinic.

Instructions for filling out attached form:

1. Sign by "Parent Signature"
2. Complete Patient Information box
3. Answer questions
4. Fill out insurance information and attach copy of card

Please have completed forms returned back to school by **Friday, October 1st .**

Please feel free to contact the Ellsworth County Health Department @ 785-472-4488 with any questions.

Ellsworth County Health Department
Kerianne Ehrlich, RN, Administrator