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.

☐ DT ☐ DTaP ☐ Tdap ☐ Td ☐ HepA ☐ HepB ☐ Hib ☐ HPV ☐ Influenza ☐ Meningococcal

☐ MMR ☐ PCV7/13 ☐ PPV23 ☐ Polio/IPV ☐ Rotavirus ☐ Varicella ☐ Other____________

______________________________ Signature of Patient or Parent/Guardian ______________ Date

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 county health department.
**Underserved children: Are not VFC eligible. May only be vaccinated with KIP vaccines needed at school entry at a county health department if enrolled in federal free or reduced-price school lunch program.

IMMUNIZATION SCREENING QUESTIONNAIRE	
1. Is the person to be vaccinated currently sick or experiencing a high fever?	__yes __no
2. Has the person to be vaccinated had a serious reaction to a vaccine in the past?	__yes __no
3. Does the person to be vaccinated have any allergies that produce a severe (anaphylactic) reaction?	__yes __no
4. Has the person to be vaccinated had a seizure or other neurological problem?	__yes __no
5. Does the person to be vaccinated have any medical problems that make it hard for him/her to fight infection?	__yes __no
6. Does the person to be vaccinated have close, regular contact with someone with a weakened immune system?	__yes __no
7. Is the person taking cortisone, prednisone, other steroids, or anti-cancer drugs, or had x-ray treatments?	__yes __no
8. Has the person to be vaccinated received blood, plasma, or immune globulin in the past twelve months?	__yes __no
9. Is the person to be vaccinated pregnant or thinking of becoming pregnant within the next three months?	__yes __no

NAME________________________ AGE_______ DOB________

PROVIDER INFORMATION					
Vaccine Provider:			Clinic Site:		
Street Address:	State:	Zip Code:	Street Address:	State:	Zip Code:

(Circle the appropriate vaccine, dose, extremity, site, route, and enter the manufacturer, lot #, and expiration date.)

FOR CLINICAL USE ONLY

VACCINE	DOSE	EXT	SITE	ROUTE	VIS DATE	MANUFACTURER LOT #	EXP DATE
DTaP DT Td Tdap	0.5 mL 1 2 3 4 5 6	RT LT	Deltoid Vastus Lat	IM			
DTaP/IPV	0.5 mL 5th DTaP--4th IPV	RT LT	Deltoid Vastus Lat	IM			
DTaP/HepB/IPV	0.5 mL 1 2 3	RT LT	Deltoid Vastus Lat	IM			
DTaP/Hib/IPV	0.5 mL 1 2 3 4	RT LT	Deltoid Vastus Lat	IM			
DTaP/Hib	0.5 mL 4	RT LT	Deltoid Vastus Lat	IM			
Hep A	0.5 mL 1.0 mL 1 2	RT LT	Deltoid Vastus Lat	IM			
Hep B	0.5 mL 1.0 mL 1 2 3	RT LT	Deltoid Vastus Lat	IM			
Hep B/Hib	0.5 mL 1 2 3	RT LT	Deltoid Vastus Lat	IM			
Hib	0.5 mL 1 2 3 4	RT LT	Deltoid Vastus Lat	IM			
HPV	0.5 mL 1 2 3	RT LT	Deltoid	IM			
Influenza LAIV TIV	0.1mL 0.2mL 0.25mL 0.50mL 1 2	RT LT	Upper Arm Deltoid Vastus Lat	Intradermal Intranasal IM			
MCV4	0.5 mL 1 2	RT LT	Deltoid	IM			
MMR	0.5 mL 1 2	RT LT	Upper Arm Thigh	SC			
MMR-V	0.5 mL 1 2	RT LT	Upper Arm Thigh	SC			
PCV7/13	0.5 mL 1 2 3 4	RT LT	Deltoid Vastus Lat	IM			
Polio/IPV	0.5 mL 1 2 3 4 5	RT LT	Upper Arm Thigh	IM SC			
PPV23	0.5 mL 1 2	RT LT	Upper Arm Deltoid Vastus Lat	SC IM			
Rotavirus	2.0 mL 1 2 3		By Mouth	Oral			
Varicella	0.5 mL 1 2	RT LT	Upper Arm Thigh	SC			
Other							

____ ________________

Signature and Title of Vaccine Administrator Date

Information for Health Professionals about the Screening Checklist for Contraindications (Children & Teens)

Are you interested in knowing why we included a certain question on the screening checklist? If so, read the information below. If you want to find out even more, consult the references listed at the bottom of this page.

1. Is the child sick today? *[all vaccines]*

There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events (1, 2). However, as a precaution with moderate or severe acute illness, all vaccines should be delayed until the illness has improved. Mild illnesses (such as otitis media, upper respiratory infections, and diarrhea) are NOT contraindications to vaccination. Do not withhold vaccination if a person is taking antibiotics.

2. Does the child have allergies to medications, food, a vaccine component, or latex? *[all vaccines]*

If a person reports they have an allergy to egg, ask if they can eat lightly cooked eggs (e.g., scrambled eggs). If they can, trivalent influenza vaccine (TIV) may be administered. If after eating eggs or egg-containing foods, they have a reaction consisting of only hives, TIV may be given and the person should be observed for at least 30 minutes. If a person experiences a serious systemic or anaphylactic reaction (e.g., hives and either swelling of the lips or tongue, acute respiratory distress, or collapse) after eating eggs, do not administer TIV or live attenuated influenza vaccine (LAIV). It is possible that they may be eligible to be given TIV, but only after they have seen a physician with expertise in the management of allergic conditions. If a person has anaphylaxis after eating gelatin, do not administer LAIV, measles-mumps-rubella (MMR), MMR+varicella (MMRV), or varicella vaccine. A local reaction is not a contraindication. For a table of vaccines supplied in vials or syringes that contain latex, go to www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/latex-table.pdf. For an extensive table of vaccine components, see reference 3.

3. Has the child had a serious reaction to a vaccine in the past?

[all vaccines] History of anaphylactic reaction (see question 2) to a previous dose of vaccine or vaccine component is a contraindication for subsequent doses (1). History of encephalopathy within 7 days following DTP/DTaP is a contraindication for further doses of pertussis-containing vaccine. Precautions to DTaP (not Tdap) include the following: (a) seizure within 3 days of a dose, (b) pale or limp episode or collapse within 48 hours of a dose, (c) continuous crying for 3 or more hours within 48 hours of a dose, and (d) fever of 105°F (40°C) within 48 hours of a previous dose. There are other adverse events that might have occurred following vaccination that constitute contraindications or precautions to future doses. Under normal circumstances, vaccines are deferred when a precaution is present. However, situations may arise when the benefit outweighs the risk (e.g., during a community pertussis outbreak).

4. Has the child 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? *[LAIV]*

Children with any of the health conditions listed above should not be given the intranasal, live attenuated influenza vaccine (LAIV). These children should be vaccinated with the injectable influenza vaccine.

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? *[LAIV]*

Children who have had a wheezing episode within the past 12 months should not be given the live attenuated influenza vaccine. Instead, these children should be given the inactivated influenza vaccine.

6. If your child is a baby, have you ever been told that he or she has had intussusception? *[Rotavirus]*

Infants who have a history of intussusception (i.e., the telescoping of one portion of the intestine into another) should not be given rotavirus vaccine.

7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problem? *[DTaP, Td, Tdap, TIV, LAIV, MMRV]*

DTaP and Tdap are contraindicated in children who have a history of encephalopathy within 7 days following DTP/DTaP. An unstable progressive neurologic problem is a precaution to the use of DTaP and Tdap, and a progressive neurologic disorder in a teen is a precaution to the use of Td. For children with stable neurologic disorders (including seizures) unrelated to vaccination, or for children with a family history of seizures, vaccinate as usual (*exception:* children with a personal or family [i.e., parent or sibling] history of seizures generally should not be vaccinated with MMRV; they should receive separate MMR and VAR vaccines). A history of Guillain-Barré syndrome (GBS) is a consideration with the following:
1) Td/Tdap: if GBS has occurred within 6 weeks of a tetanus-containing vaccine and decision is made to continue vaccination, give age-appropriate Tdap instead of Td if no history of prior Tdap; 2) Influenza vaccine (TIV or LAIV): if GBS has occurred within 6 weeks of a prior influenza vaccination, vaccinate with TIV if at high risk for severe influenza complications.

8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem? *[LAIV, MMR, MMRV, RV, VAR]*

Live virus vaccines (e.g., MMR, MMRV, varicella, rotavirus, and the intranasal live, attenuated influenza vaccine [LAIV]) are usually contraindicated in immunocompromised children. However, there are exceptions. For example, MMR is recommended for asymptomatic HIV-infected children who do not have evidence of severe immunosuppression. Likewise, varicella vaccine should be considered for HIV-infected children with age-specific CD4+ T-lymphocyte percentage at 15% or greater and may be considered for children age 8 years and older with CD4+ T-lymphocyte counts of greater than or equal to 200 cells/µL. Immunosuppressed children should not receive LAIV. Infants who have been diagnosed with severe combined immunodeficiency (SCID) should not be given a live virus vaccine, including rotavirus (RV) vaccine. For details, consult the ACIP recommendations (4, 5, 6).

9. In the past 3 months, has the child taken medications that weaken their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments? *[LAIV, MMR, MMRV, VAR]*

Live virus vaccines (e.g., MMR, MMRV, varicella, LAIV) should be postponed until after chemotherapy or long-term high-dose steroid therapy has ended. For details and length of time to postpone, consult the ACIP statement (1). To find specific vaccination schedules for stem cell transplant (bone marrow transplant) patients, see reference 7. LAIV can be given only to healthy non-pregnant individuals age 2–49 years.

10. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? *[LAIV, MMR, MMRV, VAR]*

Certain live virus vaccines (e.g., LAIV, MMR, MMRV, varicella) may need to be deferred, depending on several variables. Consult the most current ACIP recommendations or the current *Red Book* for the most current information on intervals between antiviral drugs, immune globulin or blood product administration and live virus vaccines (1, 2).

11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month? *[LAIV, MMR, MMRV, VAR]*

Live virus vaccines (e.g., MMR, MMRV, varicella, LAIV) are contraindicated one month before and during pregnancy because of the theoretical risk of virus transmission to the fetus (1, 6). Sexually active young women who receive a live virus vaccine should be instructed to practice careful contraception for one month following receipt of the vaccine (5, 8). On theoretical grounds, inactivated poliovirus vaccine should not be given during pregnancy; however, it may be given if risk of disease is imminent (e.g., travel to endemic areas) and immediate protection is needed. Use of Td or Tdap is not contraindicated in pregnancy. At the provider's discretion, either vaccine may be administered during the 2nd or 3rd trimester (9).

12. Has the child received vaccinations in the past 4 weeks?

[LAIV, MMR, MMRV, VAR, yellow fever]

If the child was given either live, attenuated influenza vaccine (LAIV) or an injectable live virus vaccine (e.g., MMR, MMRV, varicella, yellow fever) in the past 4 weeks, they should wait 28 days before receiving another vaccination of this type. Inactivated vaccines may be given at the same time or at any spacing interval.

References:

1. CDC. General recommendations on immunization, at www.cdc.gov/vaccines/pubs/acip-list.htm.
2. AAP. *Red Book: Report of the Committee on Infectious Diseases* at www.aapredbook.org.
3. Table of Vaccine Components: www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf.
4. CDC. Measles, mumps, and rubella—vaccine use and strategies for elimination of measles, rubella, and congenital rubella syndrome and control of mumps. *MMWR* 1998; 47 (RR-8).
5. CDC. Prevention of varicella: Recommendations of the Advisory Committee on Immunization Practices. *MMWR* 2007; 56 (RR-4).
6. CDC. Prevention and Control of Influenza—Recommendations of ACIP at www.cdc.gov/flu/professionals/vaccination/.
7. CDC. Excerpt from Guidelines for preventing opportunistic infections among hematopoietic stem cell transplant recipients, *MMWR* 2000; 49 (RR-10), www.cdc.gov/vaccines/pubs/down-loads/b_hsct-recs.pdf.
8. CDC. Notice to readers: Revised ACIP recommendation for avoiding pregnancy after receiving a rubella-containing vaccine. *MMWR* 2001; 50 (49).
9. CDC. Prevention of pertussis, tetanus, and diphtheria among pregnant and postpartum women and their infants: Recommendations of the ACIP. *MMWR* 2008; 57 (RR-4).

TETANUS, DIPHTHERIA, AND PERTUSSIS (Tdap) VACCINATION CONSENT FORM

☐ Mother's ☐ Father's or ☐ Significant Other Name: ______________________ Date of Birth ____/____/____

Mother's Maiden Name if it is the Mother receiving vaccine: ______________________

☐ Other: ______________________ (Example: Nursing staff, physician) Date of Birth ____/____/____

DO NOT GIVE THIS VACCINATION IF THE PERSON BEING VACCINATED HAS ANSWERED "YES" TO ANY OF THE FOLLOWING HEALTH QUESTIONS.

REFER TO: **PHONE NUMBER:**

VACCINE ADMINISTRATION RECORD

Type	Manufacturer & Lot #	Expiration Date	Injection Site	Injection Route	Administered By	VIS Date
Tdap	☐ SP Lot #________ ☐ GSK Lot #________		☐ RD ☐ LD	IM		10-4-07

RD=Right Deltoid **LD**=Left Deltoid **IM**=Intramuscular

1. Are you sick or do you have a high fever today?	☐ Yes	☐ No
2. Have you ever had Guillain-Barre´ Syndrome?	☐ Yes	☐ No
3. Have you ever had a serious reaction after an immunization?	☐ Yes	☐ No
4. Have you been told you have an allergy to the antibiotics streptomycin or neomycin?	☐ Yes	☐ No
5. Do you have a seizure problem?	☐ Yes	☐ No

The following information is not required to receive the vaccine.

6. What is your race/ethnicity (one box only): ___ Native Hawaiian/Pacific Islander

___ White ___ Black/African American ___ Hispanic/Latino

___ Asian ___ American Indian/Alaska Native ___ Unknown/Refused

The following information is not required to receive the vaccine.

7. Highest level of education: ___ Technical school

___Less than high school ___ College ___ Advanced degree

___ High school graduate ___ College graduate ___ Unknown/refused

Signature **agreeing to receive vaccination**: ______________________ Date: ____/____/____

Signature indicating that I have been given the VIS information sheet on Tdap Vaccine and **I am declining the vaccination** at this time: ______________________ Date: ____/____/____

Reason for refusal: __ Fear of needles, __ Religious/personal beliefs, __Need for more information, ___Already had it

Form to be filed in the Consent section of medical record if this is for the patient

Form to be placed in special envelope into patient's medical record if this is for a support person to the patient.

If this is for a patient, i.e. Mother on Post Partum. Use her patient sticker. If for a non-patient, use the baby's sticker. For Hospital Staff/physician leave blank.

Patient Identification

CONSENTIMIENTO PARA LA VACUNA DE TETANUS, DIPHTHERIA, PERGUSSIS (TDAP)

Nombre actual de ☐ Madre ☐ Padre ☐ Otro significativo:____________________ Fecha de nacimiento:____/____/____

Nombre de Soltera de la Madre:____

(NO DE ESTA VACUNA SI LA PERSONA QUE SERA VACUNADA HA CONTESTADO "SÍ" A UNA DE LAS RESPUESTAS DE LAS SIGUIENTES PREGUNTAS.)

REFERIR AL: **NÚMERO DE TELÉFONO:**

VACCINE ADMINISTRATION RECORD

Type	Manufacturer & Lot #	Expiration Date	Injection Site	Injection Route	Administered By	VIS Date
Tdap	☐ SP Lot #__________ ☐ GSK Lot #__________		☐ RD ☐ LD	IM		10-4-07

RD=Right Deltoid LD=Left Deltoid IM=Intramuscular

1. Esta enfermo hoy?	☐ Sí	☐ No
2. Ha tenido Síndrome Guillain-Barré?	☐ Sí	☐ No
3. Ha tenido una reacción severa después de recibir inmunizaciones?	☐ Sí	☐ No
4. Le han dicho que tiene una alergia a los antibioticos Streptomycin o Neomycin?	☐ Sí	☐ No
5. Tiene usted un problema de la incautación?	☐ Sí	☐ No

Si no Quieres responder a ninguno de estos preguntas, tienes derechoa decir que no lo quires firmar

6. Cuál es tu raza/perenencia étnica (una caja solamente): del ____ Hawainao del____ el desconocido nativo nativo del ____ americano del indio/de Alaska del ____ asiático del ____ el hispanico/de Latino del ____ americano Negro/africano del ____ blanco/pacífico del isleño/rechazó

Si no Quieres responder a ninguno de estos preguntas, tienes derechoa decir que no lo quires firmar

7. Del más alto nivel de la educación: Los school___Less técnicos del ___ que desconocido del ___ del graduado de la universidad del ___ del graduado de la High School secundaria del ___ del grado avanzado del ___ de la universidad del ___ de la High School secundaria/rechazaron

Firma indicando su acuerdo par recibir la vacuna______________________________ Fecha: _______/_______/______

Firma indicando que me han dado la informacion para la vacuna Tdap y yo rehuso la vacuna en este tiempo:

________________________________ Fecha: _______/______/______

Reason for refusal ___ Fear of needles, ___ Religious/personal beliefs, ___Need for more information, ___Other

Form to be filed in the Consent section of medical record if this is for the patient

Form to be placed in special envelope into patient's medical record if this is for a support person to the patient.

If this is for a patient, ie Mother on Post Partum. Use her patient sticker. If for a non-patient, use the baby's sticker. For Hospital Staff/physician leave blank.

Patient Identification

Compton Unified School District

WAIVER OF ALL CLAIMS (STUDENT) (Policy 6153)

COMPTON UNIFIED SCHOOL DISTRICT
Form F-14 (Rev. 08/06)

I hereby give my permission for my child, ____,

to participate in the **T-Dap St. John's Clinic** field trip as a part of his/her regular school program. This trip is

to be held on **Tuesday, September 2, 2013**

from **8:15m – 3:30 pm**, I understand my child is representing the Compton Unified School District and must abide by all the rules and regulations governing conduct as set forth by the Compton Unified School District. I understand my child must fully cooperate with all teacher and volunteer chaperones in a respectful manner. It is understood that any child not fulfilling these behavior standards will be sent home at the parent's expense.

I, the above named student's parent or guardian, knowingly withhold all claims against the Compton Unified School District, its officers and employees and the State of California for injury, accident, illness or death occurring during or by reason of this field trip or excursion; further, I hereby release

school site personnel or principal or assistant principal

from all responsibility and liability in the case of accident, illness or death while my child is on the above-mentioned field trip.

In the event of any illness, or accident, I give school site personnel or principal or assistant principal

full authority to obtain such medical treatment and/or surgery from a licensed physician and/or surgeon as deemed necessary fro the welfare of my child.

In the event of illness or accident, please contact:

______________________ Health Insurance Company	
______________________ Policy Number	______________________ Name
______________________ Group Number	______________________ Address
______________________ Number of Insured	______________________ Telephone Number

____
Possible Medical Problems (Allergies)

____
Necessary Medications

______________________ Date	______________________ Signature of Parent and/or Guardian

INSTRUCTIONS FOR SUBMISSION:
Prepare in Triplicate

DISTRIBUTION:

White:	Office of Risk Management & Safety Services
Yellow:	Principal/Department Head
Pink:	Parent or Guardian

Compton Unified School District

RENUNCIA DE TODA DEMANDA (ESTUDIANTE) (Póliza 6153)

COMPTON UNIFIED SCHOOL DISTRICT
Forma F-14 (Rev. 08/06)

Yo doy mi permiso para que mi hijo/a ______________________________

Participe en el paseo **T-Dap – St. John's Clinic** como parte del programa regular escolar. Este paseo tendrá lugar del **September 2, 2013**

Al **8:15 am – 3:30 pm**. Yo entiendo que Mi hijo/a esta representando al Distrito Escolar Unificado de Compton y deberá seguir todos los reglamentos y regulaciones que gobiernan conducta como es designado por los chaperones voluntarios en una manera respetuosa. Es entendido que cualquier niño/a que no cumpla con estos reglamentos de conducta será enviado a su casa al costo de los padres.

Yo, padre o guardián del estudiante mencionado arriba, retengo toda demanda contra el Distrito Escolar Unificado de Compton, sus oficiales, empleados y el estado de California por daño, accidente, enfermedad o muerte ocurrida durante o por razón de este paseo o excursión, además doy libertad a

School site personnel; y **principal** y assistant principal

de toda responsabilidad en caso de accidente, enfermedad o muerte mientras mi hijo/a esté en el paseo mencionado arriba.

En caso de una enfermedad, o accidente, yo doy school site personnel or principal or assistant principal

Completa autorización para obtener tal tratamiento médico y/u operación de un médico con licencia y/o cirujano como sea necesario para el bienestar de mi hijo/a.

En caso de enfermedad o accidente por favor comuníquese con:

Compañía de A seguranza de Salud	
Número de Póliza	Nombre
Numero de Grupo	Dirección
Numero de A seguranza	Número de Teléfono

Problemas Médicas (Alergias)

Medicamentos Necesarios

Fecha	Firma del Padre y/o Guardián

INSTRUCCIONES PARA SUMISIÓN:
Preparar en Triplicado

DISTRIBUCIÓN:

Blanco:	Oficina de Gerencia de Riesgo y Servicios de Seguridad
Amarillo:	Directora/Departamento Principal
Rosa:	Padre o Guardián