

**Form**

**Name:** \_\_\_\_\_ **Time:** \_\_\_\_\_

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 provided 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 share this immunization data with schools and include in the Kansas Immunization Registry for myself or on behalf of the person named below.

- DTaP    Hep A    Hep B    Hib    Polio/IPV    Pneumococcal    Tdap    Td    MMR  
Varicella    Rotavirus    HPV    Meningococcal    Typhoid    Yellow Fever    Flu    Other

**TRAVEL VACCINES: Please list countries you are visiting:** \_\_\_\_\_

**Departure Date:** \_\_\_\_\_

<b>Immunization Screening Questionnaire</b>		
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

**If the person to be vaccinated needs flu vaccine ONLY, stop here**

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 currently taking any medications?	__Yes	__No
8. Is the person taking cortisone, prednisone, other steroids, or anti-cancer drugs, or had x-ray treatments?	__Yes	__No
9. Has the person to be vaccinated received blood, plasma, or immune globulin in the past twelve months?	__Yes	__No
10. Is the person to be vaccinated pregnant or thinking of becoming pregnant within the next three months?	__Yes	__No
11. Does the person to be vaccinated smoke or live with someone who smokes?	__Yes	__No

**T.B. Skin Test Questionnaire**

Answer the following questions which apply to the person receiving the T.B. Skin Test

1. Reason for T.B. Skin test?		
2. Have you ever had a positive T.B. skin test?	__Yes	__No
3. Have you ever had or been suspected of having tuberculosis?	__Yes	__No
4. Have you had recent close contact with someone who has tuberculosis?	__Yes	__No
5. Have you received measles, mumps, rubella, or varicella vaccines within in the past month?	__Yes	__No
6. Have you had a severe allergic reaction to phenol?	__Yes	__No
7. Do you have any chronic diseases (such as leukemia, Hodgkin's Disease, diabetes, HIV, alcoholism, Or kidney disease)?	__Yes	__No
8. Have you had sexual contact or shared needles with anyone who is at risk for or has HIV/AIDS?	__Yes	__No
9. Have you taken corticosteroids or immunosuppressive therapy within the past six weeks?	__Yes	__No
10. Have you had a viral infection in the past six weeks? (chicken pox, mumps, measles, influenza)	__Yes	__No
11. Are you pregnant?	__Yes	__No
12. In the past five years, what countries have you lived in?		

**I understand I need to return in 48 to 72 hours to have my T.B. skin test read.**

**Signature of Client or Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

<b>Clinic Office Use Only:</b>							
___ T19-MED	___ No insurance	___ Native Am/Alaska Native	___ Underinsured	___ Underserved	___ T21-SCHIP	___ Insured	_____ Time Given

## Vaccine Payment

**You have requested vaccines that require payment at time of service.** Here is a list of vaccines and their current prices (**prices are subject to change**).

If you are here for Travel Vaccinations, the nurse will review the cost of any required and/or recommended vaccines based on your destination. **Clients  $\geq$  60 years of age who receive yellow fever vaccine need a doctor's order prior to vaccination.**

### **Travel Office Visit Fee \$14**

Meningitis .....	\$153
Yellow Fever .....	\$165
Hepatitis A for ages 12 mo-19 yr .....	\$50
Hepatitis A for 19 and older .....	\$76
Hepatitis B for up to age 20 .....	\$37
Hepatitis B for 20 and older .....	\$81
HPV (Gardasil) .....	\$212
Typhoid injection .....	\$85
Polio .....	\$51
MMR .....	\$88
Varicella .....	\$133
Twinrix (Hepatitis A & B combined) for 19 and older .....	\$95
Tdap for ages 11 and older .....	\$61
Td (when Tdap not recommended) .....	\$46

**Due to the fact that insurance companies (including BC/BS) typically do not cover the cost of vaccines for travel we expect payment in full today. We will be happy to file a claim for you and reimburse you any money that is paid to us or you may file the claim directly.**

### **Payment**

We accept cash, check, debit or credit cards (MasterCard or Visa) as payment.

I am prepared to pay today. (Check method of payment)

Cash\_\_\_\_ Check\_\_\_\_ Debit Card\_\_\_\_ Credit Card\_\_\_\_

Signature\_\_\_\_\_ Date\_\_\_\_\_

Name (print) \_\_\_\_\_