Lawrence · Douglas County
PUBLIC HEALTH
Advancing Health for All

INFLUENZA/COVID-19 VACCINE QUESTIONNAIRE/DOCUMENTATION FORM

I have been offered a copy of the Vaccine Information statement or EUA for the vaccine I am requesting; COVID-19 and/or Influenza. I have read, had explained to me, and understand this information. I acknowledge that my vaccine information will be entered into the Kansas Immunization Registry (WebIZ). I understand that the Notice of Privacy Practice is available on the LDCPH website.

Please PRINT information about person to receive vaccine, please fill out entirely!

Name:	**Birthdate:**		**Phone:** **Email:**
Street Address:	**City:**	**State:**	**Zip Code:**
Race: □Black/African American □Asian □American Indian/Alaskan Native □ White □Native Hawaiian/Pacific Islander □Other	**Ethnicity:** □Hispanic/Latino □Non Hispanic/Latino		**Gender**: □Male □Female □ Other, Not listed

Please Check: □ Uninsured □ Insured

IF INSURED: type of insurance: □ Medicare □ KanCare/Medicaid □ Other (list company) _____

Policy Number ID: _____ Policyholder: Self or Name _____

Policyholder DOB: _____

Policyholder Relationship □ Self □ Spouse □ Parent

Questions apply to the person receiving vaccine(s)	Select Yes or No	
1. Are you 18 year of age or older?	Yes	No
2. Are you ill today or do you have a fever?	Yes	No
3. Have you ever had an anaphylactic or serious reaction (shortness of breath, hives, throat swelling) to any vaccine, injectable medication or other substance?	Yes	No
4. Have you ever been paralyzed with Guillian Barre Syndrome?	Yes	No
5. Have you received monoclonal antibody treatment for Covid 19 illness in the last 90 days?	Yes	No

X_____Date:_____

SIGNATURE of Client /Client Representative

FOR HEALTH DEPARTMENT USE ONLY

For Vaccine Administrator Use Only

Vaccine Code	Site	Dose/Route	Lot Number	Exp. Date
High Dose Fluzone □ Private □ VFC □ 317	LVL	0.5mL	UJ748AA	6/30/2022
			UT7347KA UT7376MA UJ687AA	6/30/2022
Flublok	RVL	0.3 mL	UJ725AA	6/30/2022
Johnson & Johnson	LD			_____
Pfizer	RD		_____	_____
Moderna				

_____ Provider Signature _____Date Covid Dose #: **Dose 1** **Dose 2** **Dose 3**