THE UNIVERSITY OF KANSAS HEALTH SYSTEM

Do not write in this box

DT0004

Consent Forms

Name: _____

DOB: _____

MRN: _____

INFORMED CONSENT FOR VACCINATION

CLINIC PERSONNEL ONLY: select vaccine(s) to be administered at today's visit:

INACTIVATED Vaccines

- ☐ *Haemophilus influenzae* type b (Hib)
- ☐ Hepatitis A (HepA)
- ☐ Hepatitis B (HepB)
- ☐ Herpes zoster (ZOS)
- ☐ Human papillomavirus (HPV)
- ☑ Influenza, inactivated (IIV)
- ☐ Influenza, recombinant (RIV4)
- ☐ Meningococcal (MenACWY)
- ☐ Meningococcal B (MenB)
- ☐ Pneumococcal conjugate (PCV13)
- ☐ Pneumococcal polysaccharide (PPSV23)
- ☐ Poliovirus, inactivated (IPV: <18 yrs)
- ☐ Diphtheria, tetanus, & acellular pertussis (DTaP: <7 yrs)
- ☐ Tetanus, diphtheria, & acellular pertussis (Tdap: >7 yrs)
- ☐ Tetanus, diphtheria toxoids (Td)
- ☐ Other: _____

LIVE vaccines

- ☐ ~~Influenza,~~ live attenuated, intranasal (LAIV)
- ☐ Measles, mumps, rubella (MMR)
- ☐ Measles, mumps, rubella, varicella (MMRV)
- ☐ Rotavirus (RV) RV1 (2-dose series); RV5 (3-dose series)
- ☐ Varicella (VAR)

PATIENT or PATIENT's REPRESENTATIVE:

~~The following questions will help determine~~ which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked. If a question is unclear, please ask your provider to explain it.

IMMUNIZATION SCREENING QUESTIONNAIRE

1.	Does the patient have any allergy to gelatin or latex? [*all vaccines*]	☐ Yes	☐ No	☐ NA
2.	Has the patient ever had a serious reaction after receiving a vaccination (including a neurological disorder such as Guillain-Barré syndrome <6 weeks after previous vaccine or an allergic reaction)? [*all vaccines*]	☐ Yes	☐ No	☐ NA
3.	Have you had a positive test for COVID-19 in the last 10 days?	☐ Yes	☐ No	☐ NA

Question 4 pertains to the seasonal influenza vaccination [IIV, RIV4, LAIV]

4.	Does the patient have a severe, life threatening allergy to eggs? [IIV, RIV4, LAIV] Individuals with egg allergies can receive any licensed, recommended age-appropriate influenza vaccine and no longer need to be monitored after receiving the vaccine, regardless of allergy severity. If anaphylaxis or severe allergy, the RIV4 vaccine may be considered.	☐ Yes	☐ No	☐ NA

Questions 5-10 only pertain if patient to receive one of the following vaccines: *LAIV, MMR, MMRV, VAR, IPV, RV*

5.	Does the patient or a person in close contact with the patient currently have an illness that makes it hard for them to fight an infection? Or have they received any medication or radiation treatment that weaken their immune system (immunosuppression)? *[LAIV, MMR, MMRV, RV, VAR]*	[ ] Yes	[ ] No	[ ] NA
6.	During the past year, has the patient received a transfusion of blood or blood products, or been given immune (gamma) globulin? *[LAIV, MMR, MMRV, RV, VAR]*	[ ] Yes	[ ] No	[ ] NA
7.	Has the patient received an antiviral drug within the past 24 hours? *[LAIV, MMR, MMRV, RV, VAR]*	[ ] Yes	[ ] No	[ ] NA
8.	Female patients of child-bearing potential: Is the patient pregnant or is there a chance the patient could become pregnant during the next month? *[LAIV, MMR, MMRV, VAR, IPV]*	[ ] Yes	[ ] No	[ ] NA
9.	Has the patient received any LIVE vaccinations in the past 4 weeks? *[LAIV, MMR, MMRV, RV, VAR]*	[ ] Yes	[ ] No	[ ] NA
10.	If the patient is an infant, has he/she ever had intussusception? *[RV]*	[ ] Yes	[ ] No	[ ] NA

I have received access to information about the Vaccine Information Statement(s) (VIS) for the vaccine(s) indicated above. I have read and understand the information in the VIS(s). I understand the risks and benefits of vaccination. I ask 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.

Print name of person with authority to consent	Patient or Legal Representative Signature	Date	Time

Relationship to patient if not the patient

If the patient answered "yes" to any of the screening questions above, the signature below indicates that the provider has reviewed the responses, discussed any concerns with the patient, and is approving the immunization be given. (The provider does not need to sign if all screening answers are "no".)

Provider printed name	Provider signature	Date	Time