



School Vaccination Clinic

Student's Name: _____

Please **Initial** below if you would like your child to receive the Influenza vaccine.

Influenza Vaccine _____

You may visit www.immunize.org/vis for information about the Influenza vaccine. If you are unable to access this information, please contact the Barton County Health Department for a copy.

FORMS to complete:

Client Data Verification form - complete all sections - then sign/date at the bottom.

Vaccine Documentation/Consent Form: Complete client name, birth date & **sign**.
Complete questions 1-12 in the Immunization Screening questionnaire section.

Attach a copy of your insurance card. Insurance will be billed, and you will be sent a bill if insurance does not cover completely.

If your child does not have insurance, please mark that on the form.

Questions? Please contact Christie Rossouw @
Barton County Health Department 620-793-1902

CLIENT DATA VERIFICATION

CLIENT #:		
Legal Name :		
<i>Printed Last</i>	<i>Printed First</i>	<i>M.I.</i>
Preferred First Name :		
Interpreter Needed?	Gender :	Birthdate :
☐	☐ Male ☐ Female	
Race :	Ethnicity :	Age :
Address/City/St/Zip:		
Home/Cell Phone:		Work Phone :
Email Address:		
Interested in our monthly digital newsletter: Yes ☐ No ☐		
Primary Care Provider:		
GUARANTOR <i>(If Under 18 years of age)</i>		
Guarantor Name :		
<i>Printed Last</i>	<i>Printed First</i>	<i>M.I.</i>
Address :	Relationship:	
City/St/Zip :	Birthdate :	
Home/Cell Phone :		
Work Phone :	SSN :	
INSURANCE		
Member Name:	DOB:	
<i>Printed Last</i>	<i>Printed First</i>	<i>Required</i>
Insurance Company:	SSN:	
Member Identification # :	Group # :	
Insurance Address:	City/St/Zip :	
COMMENTS I acknowledge that I have been offered the opportunity to read the Barton County Health Department's Revised Notice of Privacy (HIPAA) effective September 23, 2013. I agree that I am seeking services voluntarily without coercion and I verify that I am not required to participate in any program with the Barton County Health Department in order to receive services. I understand that the BCHD participates in the Title X program and minors may be able to authorize services independently. I am authorizing the Barton County Health Department to submit claims for reimbursement to them on my behalf and I authorize the release of records necessary to act on this request.		
Signature: _____ Date: _____		

 CLERICAL ONLY:
 NN: _____
 Charges: _____
 WebIZ: _____

BARTON COUNTY HEALTH DEPARTMENT
 1300 Kansas Ave – Great Bend KS 67530
 Phone: (620) 793-1902 Fax: (620) 793-1903

 CLINICAL ONLY:
 NN: _____
 Charges: _____
 WebIZ: _____

07/2025

VACCINE DOCUMENTATION/CONSENT FORM

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

☐ DTaP/DT/TdaP/Td
 ☐ HepA
 ☐ HepB
 ☐ Hib
 ☐ HPV
 ☐ Influenza
 ☐ Meningococcal
 ☐ MMR
☐ PCV13
☐ PPV23
☐ Polio/IPV
☐ Rotavirus
☐ Tb ppd
☐ Varicella
 Other _____

Signature of Patient or Parent/Guardian _____

Date _____

Client Name: _____

Client Birth Date: _____

PATIENT ELIGIBILITY *** ^	
☐ TITLE 19 (<19yrs) [Medicaid] ☐ Uninsured (<19yrs) ☐ American Indian/Alaskan Native(<19yrs) ☐ Underinsured (<19yrs) [RHC/FQHC/HD only] ☐ Not VFC Eligible	☐ TITLE 21 (<19yrs) [SCHIP-STATE] ☐ 317 ☐ Medicare ☐ State ☐ VFC Eligibility not Determined/Unknown
<p>*Underinsured children: Insurance does not cover immunizations. Eligible through VFC program if vaccinated at a FQHC, RHC, or county health dept.</p> <p>**Underserved children: Are not VFC Eligible. May only be vaccinated with KIP vaccines needed for school entry at a county health dept if enrolled in federal free or reduced-price school lunch program.</p> <p>^ Underserved and Underinsured children are eligible through state funded vaccine program if vaccinated at a public county health clinic.</p>	

IMMUNIZATION SCREENING QUESTIONNAIRE	
1. Is the patient to be vaccinated currently sick or experiencing a high fever? ☐ Yes ☐ No	7. Has the patient, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems? ☐ Yes ☐ No
2. Does the patient have allergies to medications, food, a vaccine component, or latex? ☐ Yes ☐ No	8. Does the patient have cancer, leukemia, HIV/AIDS, or any other immune system problem? ☐ Yes ☐ No
3. Has the patient had a serious reaction to a vaccine in the past? ☐ Yes ☐ No	9. In the past 3 months, has the patient taken medications that weaken their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments? ☐ Yes ☐ No
4. Has the patient 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? ☐ Yes ☐ No	10. In the past year, has the patient received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? ☐ Yes ☐ No
5. If the patient 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? ☐ Yes ☐ No	11. Is the patient pregnant or is there a chance she could become pregnant during the next month? ☐ Yes ☐ No
6. If your patient is a baby, have you ever been told he or she has had intussusceptions? ☐ Yes ☐ No	12. Has the patient received vaccinations in the past 4 weeks? ☐ Yes ☐ No

PROVIDER INFORMATION			
Vaccine Provider: BARTON CO HEALTH DEPT (0005)		Clinic Site: BARTON CO HEALTH DEPT (BT CHD)	
Address: 1300 E KANSAS AVE GREAT BEND 67530		Address: 1300 E KANSAS AVE GREAT BEND, KS 67530	
Phone Number: 620-793-1902	County: BARTON	Phone Number: 620-793-1902	County: BARTON