

School Immunization Clinic Registration

School / Facility: _____

Teacher's Name (If applicable): _____

Patient Information

Last Name: _____

First: _____

Date of Birth: _____

Age: _____

Mailing Address: _____

City: _____

State: _____

Zip: _____

Legal Sex: Male Female Preferred Language: _____

Parent/Guardian Information

Last Name: _____

First: _____

Relationship: _____

Phone: _____

Email: _____

Insurance

Not Applicable; Does not have health insurance coverage.

Medical Insurance	
Insurance Company Name or Medicaid: _____	
Policy Holder Name: _____	Policy Holder's Date of Birth: _____
Policy or Medicaid ID #: _____	Group # (If applicable): _____

School Immunization Clinics follow the recommendations of the ACIP (Advisory Committee on Immunization Practices). Below are the school age immunizations recommended which your child can be given if they are due. Please select yes or no to those you do (or) do not want your child to receive:

DTaP Yes No **MMR** Yes No **Polio** Yes No **Tdap** Yes No **Varicella** Yes No
Men ACWY Yes No **Men B** Yes No **Hep A** Yes No **Hep B** Yes No

- If you have immunization questions and would like to consult with a nurse directly, please call our shot line at 208-321-2229.

Please read and sign below to indicate consent

- Vaccine Information Statements are information sheets produced by CDC that explain both the benefits and risks of vaccines. They can be found at cdc.gov/vaccines/hcp/vis.
- Participation in and withdrawal from Idaho's Immunization Reminder Information System (IRIS) is voluntary. I may call Idaho Immunization Program at 208-334-5931 to opt-out or withdraw. If I do not opt-out of IRIS in writing, my immunization records will be stored in the registry.
- I acknowledge that I have been given the opportunity to review the Consent for Services form, accessible via the QR code provided.
By signing this form, I consent to receive services in accordance with these policies.
- If flu shots are being offered at this immunization clinic, I would like my child to receive the shot. Yes No
- By signing below, I give permission for my child to receive their immunization(s) without a parent / legal guardian present.



**Consent for
Services**

 Dependent Patient Full Name

 Parent/Guardian Signature

 Date

Ada & Boise County

 707 N. Armstrong Pl. Boise, ID 83704
 208-375-5211

Elmore County

 520 E. 8th N. Mountain Home, ID 83647
 208-587-4407

Valley County

 703 1st St. McCall, ID 83638
 208-634-7194

Screening Checklist for Contraindications to Vaccines for Children and Teens

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer 'yes' to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

Patient Name: _____

Date of Birth: _____

	Yes	No	I Don't Know
1. Is the child sick today?			
2. Does the child have allergies to medicine, food, a vaccine component, or latex?			
3. Has the child had a serious reaction to a vaccine in the past?			
4. Does the child have a long-term health problem with heart, lung (including asthma), kidney, liver, nervous system, or metabolic disease (e.g., diabetes), a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are they taking regular aspirin or salicylate medication?			
5. For children age 2 through 4 years: Has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?			
6. For babies: Have you ever been told the child had intussusception?			
7. Has the child, a sibling, or a parent had a seizure; has the child had a brain or other nervous system problem?			
8. Has the child ever been diagnosed with a heart condition (myocarditis or pericarditis) or have they had Multisystem Inflammatory Syndrome (MIS-C) after an infection with the virus that causes COVID-19?			
9. Does the child have an immune-system problem such as cancer, leukemia, HIV/AIDS?			
10. In the past 6 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs to treat rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?			
11. Does the child's parent or sibling have an immune system problem?			
12. In the past year, has the child received immune (gamma) globulin, blood/blood products, or an antiviral drug?			
13. Is the child/teen pregnant?			
14. Has the child received vaccinations in the past 4 weeks?			
15. Has the child ever felt dizzy or faint before, during, or after a shot?			
16. Is the child anxious about getting a shot today?			

Form completed by _____	Date _____	Form reviewed by _____	Date _____
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Did you bring your Immunization Record card with you? **Yes** **No**

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.

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