CENTRAL DISTRICT HEALTH

Serving Ada, Boise, Elmore, and Valley Counties
cdh.idaho.gov

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 **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.*

Consent for Services

- *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.*

_____
Dependent Patient Full Name

_____ _____
Parent/Guardian Signature Date

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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

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.