Adult Immunization Clinic Registration

Facility: _____

Patient Information

Last Name: _____ First: _____

Date of Birth: _____ Age: ____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Legal Sex: ◯ Male ◯ Female Preferred Language: _____

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 to receive the shot.* ◯ *Yes* ◯ *No*

Consent for Services

_____
Patient Full Name

_____ _____
Signature Date

Screening Checklist for Contraindications to Vaccines for Adults

For patients: The following questions will help us 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 we need to ask you more questions. 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. Are you sick today?	◯	◯	◯
2. Do you have allergies to medications, food, a vaccine component, or latex?	◯	◯	◯
3. Have you ever had a serious reaction after receiving a vaccine?	◯	◯	◯
4. Do you have any of the following: a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?	◯	◯	◯
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	◯	◯	◯
6. Do you have a parent, brother, or sister with an immune system problem?	◯	◯	◯
7. In the past 6 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	◯	◯	◯
8. Have you had a seizure or a brain or other nervous system problem?	◯	◯	◯
9. Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19?	◯	◯	◯
10. In the past year, have you received immune (gamma) globulin, blood/blood products, or an antiviral drug?	◯	◯	◯
11. Are you pregnant?	◯	◯	◯
12. Have you received any vaccinations in the past 4 weeks?	◯	◯	◯
13. Have you ever felt dizzy or faint before, during, or after a shot?	◯	◯	◯
14. Are you 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 vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.