

IIC 2020 Immunization Screening Questionnaire ENGLISH

6919 East 10th Street, Suite C2, Indianapolis IN 46219

School: _____

Teacher's Name: _____

Room # _____

Complete the Following for the Person Who is Being Vaccinated:

PATIENT Name: FIRST _____ MIDDLE _____ LAST _____

Phone: (____) - _____ - _____ Birth Date: ____/____/____ Age: _____ Sex: F M

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

Parent/Guardian Full Name: _____ Ethnicity: Hispanic/Latino Not Hispanic/Latino

Race: (Check all that apply) American Indian/Alaskan Native Asian Black Native Hawaiian/Pacific Islander White Unknown

Insurance Status (Check box)

NO INSURANCE

MEDICAID

Company: _____ Medicaid #: _____ Don't know

PRIVATE or COMMERCIAL INSURANCE (NOT MEDICAID)

Insurance Company: _____ Insurance Policy ID: _____ Group # _____ (if one applies): _____

Policy Holder Name: _____ Policy Holder Birth Date: ____/____/____ SSN: _____

Policy Holder Relationship to Patient: _____

Questions for the Person Getting Vaccinated:

NO YES

	NO	YES
1. Is the person to be vaccinated sick today? If yes, what are their symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the person to be vaccinated have any allergies to medications, foods, a vaccine component or latex? Please list allergies:	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the person to be vaccinated ever had a serious reaction to a vaccine in the past? If yes, please explain:	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the person to be vaccinated ever had Guillian-Barre Syndrome (GBS)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia, or other blood disorders?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does the person to be vaccinated have cancer, leukemia, AIDS or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>
7. Does the person to be vaccinated take cortisone, prednisone, other steroids, or anticancer drugs, or have you had x-ray treatments for cancer?	<input type="checkbox"/>	<input type="checkbox"/>
8. Has the person to be vaccinated had a seizure, brain, or other nervous system problem?	<input type="checkbox"/>	<input type="checkbox"/>
9. Does the person to be vaccinated smoke?	<input type="checkbox"/>	<input type="checkbox"/>
10. During the past year, has the person to be vaccinated received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?	<input type="checkbox"/>	<input type="checkbox"/>
11. For women: Is the person to be vaccinated pregnant or is there a chance they could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>
12. Has the person to be vaccinated received any vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>

By signing below, I consent to the use and disclosure of my or my child's personal health information for the purpose of health care operations, along with the assignment of all payments from the insurer listed above to VaxCare for the services rendered.

Consent for Use of Protected Health Information & Claims Assignment: I hereby consent to and acknowledge the receipt of a Notice of Privacy Practices regarding the use and disclosure of my personal health information for the purpose of health care operations, along with the assignment of all payment from the insurer listed above to VaxCare associated with the services contemplated herein. Vaccine Authorization: My signature on this form indicates that I have requested that the vaccine indicated below be administered to me or my dependent by a VaxCare representative. I relieve VaxCare, the VaxCare partner, the administering person and personnel of any liability for any reactions that should occur. I unconditionally and irrevocably waive any right to a trial by jury, to the maximum extent allowed by law, for any claim or action arising out of or related to this service, and that any such claim or action shall be determined solely on an individual

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basis through arbitration in accordance with Commercial Arbitration Rules of the American Arbitration Association. Neither I nor VaxCare shall be entitled to join or consolidate claims in arbitration by or against other individuals or entities, or arbitrate any claims as a representative member of a class or in private attorney general capacity. In the case of the occupational exposure, VaxCare has patient's permission for blood testing for patient and employee safety alike. I have read or have had explained to me the information from the Vaccine Information Statement(s) and understand the risks (including adverse reactions) and benefits of the vaccine(s). If consenting for another, I have the legal authority, based on my relationship to the individual indicated above, to consent to this vaccine(s) administration.

I consent to myself/my child being vaccinated with all recommended vaccinations that are due at this time. If I want to refuse any specific vaccine I will call 317-628-7116 or email: clinic@vaccinateindiana.org Vaccines that may be administered based on you/your child's vaccination record: DTaP, Hepatitis A, Hepatitis B, HIB, Polio, Influenza, MMR, Human Papilloma Virus, Meningitis, PCV13, Varicella

Electronic Signatures: Electronic signatures are used for health records as a means of attestation of electronic health record entries, transcribed documents, and computer-generated documents. By checking this box and submitting by name and date on this form I understand that I am executing an electronic signature which is considered legally binding as a means to provide consent to the terms and conditions outlined on this form. It is VaxCare's policy to accept electronic signature in lieu of physical signature. This process operates within the secured infrastructure, ensuring integrity of process and minimizing risk of unauthorized activity in the design, use, and access of the electronic health record.

Signature: X _____ **Date:** _____

Parent/Guardian signature required if under 18 years old

CLINIC USE ONLY

VACCINE	VIS	MANUFACTURER /LOT # / EXP DATE	INJECTION SITE	Route
DTAP	4/01/20		<input type="checkbox"/> LA <input type="checkbox"/> RA	<input type="checkbox"/> IM
DTAP/IPV	4/01/20 10/30/19		<input type="checkbox"/> LA <input type="checkbox"/> RA	<input type="checkbox"/> IM
HEP A	7/20/16		<input type="checkbox"/> LA <input type="checkbox"/> RA	<input type="checkbox"/> IM
HEP B	08/15/19		<input type="checkbox"/> LA <input type="checkbox"/> RA	<input type="checkbox"/> IM
HEP A/B	7/20/16 8/15/19		<input type="checkbox"/> LA <input type="checkbox"/> RA	<input type="checkbox"/> IM
HPV9	10/30/19		<input type="checkbox"/> LA <input type="checkbox"/> RA	<input type="checkbox"/> IM
Influenza	08/15/19		<input type="checkbox"/> LA <input type="checkbox"/> RA	<input type="checkbox"/> IM
MCV4	8/15/19		<input type="checkbox"/> LA <input type="checkbox"/> RA	<input type="checkbox"/> IM
MenB	8/15/19		<input type="checkbox"/> LA <input type="checkbox"/> RA	<input type="checkbox"/> IM
MMR	8/15/19		<input type="checkbox"/> LA <input type="checkbox"/> RA	<input type="checkbox"/> SC
MMR/V	8/05/19		<input type="checkbox"/> LA <input type="checkbox"/> RA	<input type="checkbox"/> SC
PCV-13	10/30/19		<input type="checkbox"/> LA <input type="checkbox"/> RA	<input type="checkbox"/> IM
POLIO	10/30/19		<input type="checkbox"/> LA <input type="checkbox"/> RA	<input type="checkbox"/> IM
PPSV23	10/30/19		<input type="checkbox"/> LA <input type="checkbox"/> RA	<input type="checkbox"/> IM
CHICKENPOX (VARICELLA)	8/15/19		<input type="checkbox"/> LA <input type="checkbox"/> RA	<input type="checkbox"/> SC
TDAP	4/01/20		<input type="checkbox"/> LA <input type="checkbox"/> RA	<input type="checkbox"/> IM

VACCINATOR NAME AND CREDENTIALS: _____ DATE: _____

ENTERED INTO CHIRP BY: _____ DATE: _____