Dignity Health
Chandler Regional Medical Center

Appointments: go to
www.dignityhealth.org/chandlerimmunizations
Or call 480-728-2004

ADULT Immunization Registration

Please read and complete all highlighted areas on all 4 pages:

First Name:	Date of Birth:	
Last Name:	Age:	
Middle Name:	Gender/Sex:	
Phone:		
Street Address:	City:	Zip Code:

Check ALL That Apply:

_____ I **DO NOT** have health insurance (Uninsured)

_____ I have health insurance that **does NOT pay for** vaccines (Under insured)

_____ I have health insurance **that covers all vaccines**.-- **STOP and see receptionist.**

I agree to the health provider giving vaccinations to release information about all vaccinations given to me or the person for whom I am authorized to give consent to the Arizona State Immunization Information System (ASIIS) to provide information about what immunizations have been received. I understand that I am not required to agree to the release of this information in order to receive the vaccinations I request.

I acknowledge I have been offered a copy of the Patient Rights and Responsibilities that informs me how to file a grievance if I feel my rights have been compromised.

I acknowledge I have been given a copy and have read, or have had explained to me, the CDC "Vaccine Information Sheet" for the disease(s) and vaccine(s) to be given. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) checked be given to me. My initials will indicate my approval for the vaccines recommended to me on the vaccine administration form.

Signature:	**Date:**

Health Information Exchange (HIE) State Participation Acknowledgement

I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding Dignity Health's participation in The Network, the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.

Acknowledgment
Signature: _____ Date: _____

If signed by anyone other than the patient, please indicate relationship:

Print Name: _____ Relationship: _____

Joint Notice of Privacy Practices for Health Information (NPP) Acknowledgement

Effective April 14, 2003 the law requires that **Chandler Regional Medical Center** give to a patient a copy of its Notice of Privacy Practices for Health Information. This notice describes how medical information about you may be disclosed and how you can get access to this information. We will give you a copy at the time of first treatment and, if we change our notice, thereafter at the next treatment visit. By signing below, you acknowledge receipt of such as the patient, the patient's personal representative, the patient's authorized agent, or an individual involved in the patient's medical care.

Patient Name: _____ Medical Record # _____

Acknowledgment
Signature: _____ Date: _____

If signed by anyone other than the patient, please indicate relationship:

Print Name: _____ Relationship: _____

OFFICAL USE:

I provided a copy of the NPP to the patient/patients representative but was unable to obtain his/her written acknowledgement of receipt of such for the following reasons:

_____
_____

I have attempted to provide to the patient/patients representative a copy of the NPP, but was unable to do so for the following reasons:

_____
_____

Signature of
Hospital Representative: _____Date:_____

Print Name: _____Department: _____

Dignity Health
Chandler Regional Medical Center

Screening Checklist for Contraindications to Vaccines for Adults

Patient Name:_____

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 additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't know
1. Are you sick today? Have you had any of these kinds of symptoms in the past 24 hours? - Fever, body aches, fatigue - Cough, sore throat, shortness of breath - Headache, sudden loss of smell or taste - Nausea or diarrhea			
2. Do you have allergies to medications, food, a vaccine component, or latex?			
3. Have you ever had a serious reaction after receiving a vaccination or injectable medication?			
4. Do you have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g. diabetes), asthma, a blood disorder, no spleen, complement component deficiency, 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 3 months, have you taken medications that: • affect your immune system, such as prednisone or other steroids • anticancer drugs or radiation treatment • drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis • drugs that thin your blood, such as warfarin, Eliquis, or Xarelto			
8. Have you had a seizure or a brain or other nervous system problem such as Guillain-Barre syndrome?			
9. During the past year, have you received a transfusion of blood, blood products, monoclonal antibody treatment or been given immune (gamma) globulin or an antiviral drug?			
10. For women: Are you pregnant or is there a chance you could become pregnant?			
11. Have you received any vaccinations in the past 4 weeks? Last Covid-19 vaccine date:			

Form completed by:_____ date:_____

Form reviewed by:_____ date:_____

Reference: www.immunize.org/catg.d/p4065.pdf • Item #P4065 (8/19)

Dignity Health
Chandler Regional Medical Center

Community Wellness
1955 W. Frye Rd.
Chandler, AZ 85224

ADULT VACCINE ADMINISTRATION FORM

COMMUNITY WELLNESS
IMMUNIZATION PROGRAM

PRINTED NAME:_____ DATE OF BIRTH: _____
MM/DD/YYYY

ALLERGIES: _____ E-MAIL ADDRESS: _____

1) I REQUEST THAT THE VACCINES MARKED BE GIVEN TO ME.
2) I UNDERSTAND THE RISKS AND BENEFITS OF THE VACCINES I AM REQUESTING
3) I HAVE BEEN GIVEN THE VACCINE INFORMATION SHEET AND MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

SIGNATURE OF VACCINE RECIPIENT:_____ DATE:_____
MM/DD/YYYY

BELOW LINE FOR CLINIC STAFF ONLY

SCREENED BY:_____ ADMIN. DATE & DATE VIS GIVEN:_____

SPECIAL CONSIDERATIONS: _____

HIGH DOSE	FLU
VIS EDIT. DATE	VIS EDIT. DATE
8/6/2021	8/6/2021
ACCEPT:	ACCEPT:
DECLINE:	DECLINE:

Bivalent Pfizer Covid Vaccine gray cap 0.3ml RD LD IM FACT SHEET DATE	HEP B	HPV9	MMR		PCV20		TDAP	VARICELLA		ZOSTER
#	#	#	#	#	#		#	#		#
	HeplisavB LD IM	LD IM	RA IM SQ		RD IM		LD IM	LA IM SQ		SHINGRIX LD IM
	VIS EDIT. DATE	VIS EDIT. DATE	VIS EDIT. DATE		VIS EDIT. DATE		VIS EDIT. DATE	VIS EDIT. DATE		VIS EDIT. DATE
	5/12/23	8/6/21	8/6/21		5/12/23		8/6/21	8/6/21		2/4/22
ACCEPT:	ACCEPT:	ACCEPT:	ACCEPT:	ACCEPT:	ACCEPT:		ACCEPT:	ACCEPT:		ACCEPT:
DECLINE:	DECLINE:	DECLINE:	DECLINE:	DECLINE:	DECLINE:		DECLINE:	DECLINE:		DECLINE:

MANUFACTURER, LOT NUMBER	NAME/TITLE OF ADMINISTRATOR	LABEL: MANUFACTURER, LOT NUMBER	NAME/TITLE OF ADMINISTRATOR