

ADULT Immunization Registration

Appointments: go to www.dignityhealth.org/chandlerimmunizations or call 480-728-2004. Masks are required for entrance. Only the person needing vaccination and one adult will be permitted into the center. If you had any of these 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, please delay your visit.

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: _____

OFFICIAL 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

Health Information Exchange (HIE)
and Notice of Privacy Practices (NPP)

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.

Form reviewed by: _____ date: _____

ADULT VACCINE ADMINISTRATION FORM

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

HIGH DOSE VIS EDIT. DATE 8/6/2021	FLU VIS EDIT. DATE 8/6/2021	SCREENED BY: _____		ADMIN. DATE & DATE VIS GIVEN: _____					
				ADMIN FEE \$15.00					
				COLLECTED ☐					
				DECLINED ☐					

COVID-19	HEP A	HEP B	HPV9	MMR	PCV13	PPSV23	TDAP	VARICELLA	ZOSTER
#	#	#	#	#	#	#	#	#	#
RD LD IM VIS EDIT. DATE	RD IM VIS EDIT. DATE	LD IM VIS EDIT. DATE	LD IM VIS EDIT. DATE	RA SQ VIS EDIT. DATE	Prenar RD IM VIS EDIT. DATE	RD IM VIS EDIT. DATE	LD IM VIS EDIT. DATE	LA SQ VIS EDIT. DATE	SHINGRIX IM VIS EDIT. DATE
7/28/20	8/15/19	10/30/19	8/15/19	10/30/19	10/30/19	4/1/20	8/15/19	10/30/19	10/30/19
ACCEPT:	ACCEPT:	ACCEPT:	ACCEPT:	ACCEPT:	ACCEPT:	ACCEPT:	ACCEPT:	ACCEPT:	ACCEPT:
DECLINE:	DECLINE:	DECLINE:	DECLINE:	DECLINE:	DECLINE:	DECLINE:	DECLINE:	DECLINE:	DECLINE:

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