Dignity Health
Chandler Regional Medical Center

# Child 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 complete all highlighted areas. Please read and complete all 4 pages.**

| | | | |
|---|---|---|---|
| Child's First Name: | | Age: | |
| Last Name: | | | |
| Middle Name: | | Date of Birth: | |
| Phone: | | Gender/Sex: | |
| Address: | | | |
| City: | State: | Zip Code: | |
| Parent/Guardian Name: | | | |
| Mother's First Name: | | Mother's Maiden Name: | |

**CHECK ONE :**

(1) _____ child is enrolled in **AHCCCS**? Which plan? _____
(2) _____ Child **does NOT have** health insurance
(3) _____Child is American Indian or Alaskan Native
(4) _____ Child has private insurance that **does NOT cover** one or more vaccines.
(5)_____ Child has private insurance that **covers all vaccines**. **Please Stop and see registrar.**

## Please read below and sign

☐ **INTERPRETER USED**

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), other health care providers, and school in order to avoid receiving unnecessary vaccinations and 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) checked below. 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 below be given to me or the person named above for whom I am authorized to make this request. My initials will indicate my approval for the vaccines recommended to me on the vaccine administration form.

**Signature of Parent/Guardian:** **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: _____

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**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: _____

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**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: _____

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# Screening Checklist for Contraindications to Vaccines for Children and Teens

PATIENT NAME _____

DATE OF BIRTH ____ / ____ / ____
month day year

**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.

| | yes | no | don't know |
|---|---|---|---|
| **1.** Is the child sick today? Has your child had any of these kinds of symptoms in the past 24 hours? -fever, body aches, fatigue, sore throat, shortness of breath, headache, sudden loss of smell or taste, nausea, diarrhea | ☐ | ☐ | ☐ |
| **2.** Does the child have allergies to medications, 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 lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Is he/she on long-term aspirin therapy? | ☐ | ☐ | ☐ |
| **5.** If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months? | ☐ | ☐ | ☐ |
| **6.** If your child is a baby, have you ever been told he or she has had intussusception? | ☐ | ☐ | ☐ |
| **7.** Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems? | ☐ | ☐ | ☐ |
| **8.** Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem? | ☐ | ☐ | ☐ |
| **9.** Does the child have a parent, brother, or sister with an immune system problem? | ☐ | ☐ | ☐ |
| **10.** In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments? | ☐ | ☐ | ☐ |
| **11.** In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? | ☐ | ☐ | ☐ |
| **12.** Is the child/teen pregnant or is there a chance she could become pregnant during the next month? | ☐ | ☐ | ☐ |
| **13.** Has the child received vaccinations in the past 4 weeks? | ☐ | ☐ | ☐ |

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.

immunization action coalition
IAC
immunize.org

Technical content reviewed by the Centers for Disease Control and Prevention

Saint Paul, Minnesota ▪ 651-647-9009 ▪ www.immunize.org ▪ www.vaccineinformation.org

www.immunize.org/catg.d/p4060.pdf ▪ Item #P4060 (8/19)

Dignity Health
Chandler Regional Medical Center
Community Wellness
1955 W. Frye Rd.
Chandler, AZ 85224

# CHILD VACCINE ADMINISTRATION FORM

CHILD'S NAME : _____ DATE OF BIRTH: _____
MM/DD/YYYY

AGE:_____ CHILDS WEIGHT:_____ ALLERGIES:_____

BELOW USE FOR SCREENER ONLY

SCREENED BY:_____DATE OF ADMIN./VIS GIVEN:_____ ☐ MULTI-VACCINE VIS GIVEN EDITION DATE 4/1/2020

| Dtap | Pediarix | Pentacel | Dtap-IPV | Hep A | Hep B | Hib | HPV9 | Flu | Flu |
|---|---|---|---|---|---|---|---|---|---|
| # | # | # | # | # | # | # | # | PVT | VFC |
| LVL LD IM | LVL LD IM | LVL LD IM | LVL LD IM | RVL RD IM | LVL LD IM | MERCK | MERCK | SITE_____ | SITE_____ |
| VIS EDIT. DATE | Dtap-IPV-HepB | Dtap-IPV/Hib | DTaP vis4/1/20 | VIS EDIT. DATE | VIS EDIT. DATE | LVL LD IM | RD IM | IM | IM |
| 4/1/2020 | Dtap vis 4/1/20 IPV vis 10/30/19 HepB vis 8/15/19 | Dtap vis 4/1/20 IPV vis 10/30/19 Hib vis 10/30/19 | IPV vis 10/30/19 | 7/28/2020 | 8/15/2019 | VIS EDIT. DATE 10/30/2019 | VIS EDIT. DATE 10/30/2019 | VIS EDIT. DATE 8/6/2021 | VIS EDIT. DATE 8/6/2021 |
| ACCEPT: | ACCEPT: | ACCEPT: | ACCEPT: | ACCEPT: | ACCEPT: | ACCEPT: | ACCEPT: | ACCEPT: | ACCEPT: |
| DECLINE: | DECLINE: | DECLINE: | DECLINE: | DECLINE: | DECLINE: | DECLINE: | DECLINE: | DECLINE: | DECLINE: |

| IPV | MCV4 | MEN B | MMR | PCV 13 | Rota | Tdap | VAR | MMRV | COVID-19 |
|---|---|---|---|---|---|---|---|---|---|
| # | # | # | # | # | # | # | # | # | |
| LA SQ | RD IM | BEXSERO | MERCK | PREVNAR | MERCK | LD IM | MERCK | MERCK | SITE_____ |
| VIS EDIT. DATE | VIS EDIT. DATES | LD IM | RA SQ | RVL RD IM | ORAL | VIS EDIT. DATE | LA SQ | RA SQ | IM |
| 10/30/2019 | 8/15/2019 | VIS EDIT. DATE 8/15/2019 | VIS EDIT. DATE 8/15/2019 | VIS EDIT. DATE 10/30/2019 | VIS EDIT. DATE 10/30/2019 | 4/1/2020 | VIS EDIT. DATE 8/15/2019 | VIS EDIT. DATE 8/15/2019 | VIS EDIT. DATE |
| ACCEPT: | ACCEPT: | ACCEPT: | ACCEPT: | ACCEPT: | ACCEPT: | ACCEPT: | ACCEPT: | ACCEPT: | ACCEPT: |
| DECLINE: | DECLINE: | DECLINE: | DECLINE: | DECLINE: | DECLINE: | DECLINE: | DECLINE: | DECLINE: | DECLINE: |

| VACCINE LABEL: VACCINE, MANUFACTURER, LOT NUMBER | NAME/TITLE OF ADMINISTRATOR |
|---|---|
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