INFORMATION ABOUT THE CHILD RECEIVING THE VACCINE

FIRST NAME	MI	LAST NAME	ADDRESS
DOB *(mm/dd/yyyy)*	AGE		CITY / STATE / ZIP
	◯ mo ◯ yrs		
SEX ◯ M ◯ F	WEIGHT LBS	OFFICE USE ONLY ☐ Mature Minor	PRIMARY PHONE *(###) ###-####* / PARENT/GUARDIAN EMAIL
PARENT/GUARDIAN FIRST & LAST NAME PRINTED LEGIBLY			

HEALTH INSURANCE STATUS *(Required Information - however, we do not bill)*

CHILDREN (18 AND YOUNGER)

◯ UNINSURED ◯ UNDER-INSURED ◯ CHIP ◯ MEDICAID ◯ PRIVATE INSURANCE ◯ ALASKAN NATIVE / AMERICAN INDIAN

SCREENING QUESTIONS

	YES	NO	DON'T KNOW
1. Is this child sick today? *(i.e., fever above 101°F)*	◯	◯	◯
2. Has this child ever had an allergic or serious reaction *(i.e., anaphylactic reaction, hives, swelling, respiratory distress, wheezing)* to any of the *items below* that required treatment with epinephrine or EpiPen® or caused the child to go to the hospital? ● Polyethylene glycol *(PEG),* which is found in some medications, such as laxatives and preparations for colonoscopy procedures ● Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids ● Medications ● Food ● Latex	◯	◯	◯
3. Does this child have a long-term health problem with heart *(including pericarditis and/or myocarditis)*, lung, kidney, or metabolic disease *(e.g., diabetes)*, asthma, a blood disorder *(including taking blood thinners, history of heparin induced thrombocytopenia (HIT), etc.)*, no spleen, complement component deficiency, Multi-system Inflammatory Syndrome *(MIS-C or MIS-A)*, a cochlear implant, or a spinal fluid leak?	◯	◯	◯
● Is this child on long-term aspirin therapy?	◯	◯	◯
4. Does this child or a close family member have cancer, leukemia, HIV, or any other immune system problem?	◯	◯	◯
5. In the past 3 months, has this child taken medications that affect the immune system, such as prednisone, other steroids, or anti-cancer drugs, drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis, or has this child had radiation treatments?	◯	◯	◯
6. During the past year, has this child received a transfusion of blood or blood products, or been given immune *(gamma)* globulin, monoclonal antibodies, convalescent serum, or an antiviral drug?	◯	◯	◯
7. Has this child received any vaccinations in the past 4 weeks? If so, which one? _____	◯	◯	◯
8. Has this child received dermal fillers?	◯	◯	◯
9. ***For FEMALES:*** Is this child pregnant or is there a chance she could become pregnant during the next month?	◯	◯	◯
● Is this child breastfeeding?	◯	◯	◯
10. Does this child have any physical, developmental, or behavioral limitations? If yes, and to provide additional support if needed, what limitation(s)? _____	◯	◯	◯

11. Please rate this child's anxiety about the vaccination process. ◯ *no anxiety* ◯ *somewhat anxious* ◯ *anxious* ◯ *very anxious*

OFFICE USE ONLY	MEDICAL SCREENER INITIALS _____	AVAILABLE IMMUNIZATION RECORD IN IIS?	YES	NO
		REQUIRED VIS Offered *(please circle)*	YES	NO

CONSENT

I have read or have had explained to me the above information and received a copy of the Vaccine Information Statement and understand Spokane Regional Health District's (SRHD) Privacy Policy. I have had a chance to ask questions, which were answered to my satisfaction. I consent to inclusion of this data in the Washington State Immunization Information (IIS) Registry. I believe I understand the benefits and risks of the vaccines checked on page two and request that the vaccine be given to me or the person named for whom I am authorized to make this request. Also, by signing this consent, I give permission for myself (and any of my children, if applicable) to be filmed or photographed during the immunization clinic today.

_____ PARENT OR GUARDIAN SIGNATURE

_____ DATE

☐ PARENTAL/GUARDIAN CONSENT OBTAINED BY PHONE Staff Initials _____ Time _____ a.m. / p.m.

CHILD VACCINES

VACCINES RECOMMENDED				
☐ DTAP *(6 & younger)*	☐ DTAP / HEP B / IPV *(up to 6 years only)*	☐ DTAP / HEP B / HIB / IPV *(6 wks to 4 yrs)*	☐ DTAP / HIB / IPV *(2 mo to 4 yrs)*	☐ DTAP / IPV *(4-6 years only, #4 & #5)*
☐ HEP A	☐ HEP B	☐ HIB	☐ HPV9	☐ INFLUENZA *(Flu)* ☐ *IM* ☐ *NASAL*
☐ IPV *(POLIO)*	☐ MenACWY	☐ MEN B	☐ MMR *(live)*	☐ MMR / V *(combo & live)* *(12 mo-12 yrs)*
☐ PCV-13	☐ TDAP *(7 & older)*	☐ VARICELLA *(Chickenpox)*	☐ Covid-19 - Pfizer *(12 yrs & older, #1 & #2)*	☐ Covid-19 - Pfizer *(5-11 yrs old)*
☐ Covid-19 - Pfizer *(6 mos - 4 yrs old)*				

VACCINE	VIS	MANUFACTURER	LOT #	EXP DATE	SITE ADMINISTERED	ROUTE
		(PLEASE WRITE INFORMATION BELOW CLEARLY)				
DTAP	08.06.21				☐ R ☐ L / ☐ Arm ☐ Thigh	IM
DTAP / HEP B / IPV	10.15.21				☐ R ☐ L / ☐ Arm ☐ Thigh	IM
DTAP / HEP B / HIB / IPV	10.15.21				☐ R ☐ L / ☐ Arm ☐ Thigh	IM
DTAP / HIB / IPV	10.15.21				☐ R ☐ L / ☐ Arm ☐ Thigh	IM
DTAP / IPV	10.15.21				☐ R ☐ L / ☐ Arm ☐ Thigh	IM
HEP A	10.15.21				☐ R ☐ L / ☐ Arm ☐ Thigh	IM
HEP B	10.15.21				☐ R ☐ L / ☐ Arm ☐ Thigh	IM
HIB	08.06.21				☐ R ☐ L / ☐ Arm ☐ Thigh	IM
HPV9	08.06.21				☐ R ☐ L / ☐ Arm ☐ Thigh	IM
INFLUENZA *(FLU)*	08.06.21				☐ R ☐ L / ☐ Arm ☐ Thigh	IM
FLUMIST	08.06.21				☐ Nose	NASAL
IPV *(POLIO)*	08.06.21				☐ R ☐ L / ☐ Arm ☐ Thigh	IM
MenACWY	08.06.21				☐ R ☐ L / ☐ Arm ☐ Thigh	IM
MEN B	08.06.21				☐ R ☐ L / ☐ Arm ☐ Thigh	IM
MMR	08.06.21				☐ R ☐ L / ☐ Arm ☐ Thigh	SC
MMR / V	08.06.21				☐ R ☐ L / ☐ Arm ☐ Thigh	SC
PCV13	02.04.22				☐ R ☐ L / ☐ Arm ☐ Thigh	IM
TDAP	08.06.21				☐ R ☐ L / ☐ Arm ☐ Thigh	IM
VARICELLA	08.06.21				☐ R ☐ L / ☐ Arm ☐ Thigh	SC
Covid-19 - Pfizer *(12 yrs & older, #1 & #2)*		PFIZER			☐ R ☐ L / ☐ Arm ☐ Thigh	IM
Covid-19 - Pfizer *(5-11 yrs old)*		PFIZER			☐ R ☐ L / ☐ Arm ☐ Thigh	IM
Covid-19 - Pfizer *(6 mos - 4 yrs old)*		PFIZER			☐ R ☐ L / ☐ Arm ☐ Thigh	IM

VACCINATOR NAME / INITIALS
AND CREDENTIALS _____

Please PRINT your information clearly