

Immunization Pre-registration Checklist for Stick 'EM 2017

_____ **Fill out Demographic form completely (pg1)**

****including insurance information if applicable**

_____ **Complete Health Questionnaire (pg2)**

_____ **Make copy of child's immunization record
to send with packet.**

_____ **Return completed packet to:**

Your School Nurse

OR

Mohave County Health Department

2001 College Dr. Suite 115

Lake Havasu City, AZ

Fax: 928-453-0740

COMPLETED PACKETS DUE BY JULY 10TH!

What to bring with you on day of Immunizations:

- ❖ Insurance or AHCCCS card if applicable**
- ❖ Child's Immunization Record to be stamped**
- ❖ Parent or Legal Guardian of child**

For Questions call 928-453-0703 extension # 3026

Screening Questionnaire for Child and Teen Immunization

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

Child's Name: _____ **Date of Birth:** _____

		Yes	No	Don't Know
1.	Is the child sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Does the child have allergies to ANYTHING (medications, food, vaccines, or latex)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Has the child had a serious reaction to a vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	If the child to be vaccinated is between the ages of 2 and 4 years, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	If your child is a baby, have you ever been told he/she has had intussusception (bowel obstruction)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Does the child have cancer, leukemia, AIDS, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	In the past 3 months, has the child taken medications that weaken their immune system, such as cortisone, prednisone, other steroids, anticancer drugs, any Immunosuppressant drugs, or had radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.	Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.	Has the child received <i>any</i> vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.	Does the child have a history of fainting?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.	Is the child currently taking <i>any</i> medications?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15.	Has the child had chicken pox?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16.	Did you bring your child's immunization record card with you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Form completed by: _____ **Date:** _____

Nurse's signature: _____ **Date:** _____

It is important to have a personal record of your child's vaccinations. If you don't have a personal record, ask the healthcare provider to give you one with all your child's vaccinations on it. Keep this record in a safe place and bring it with you every time you seek medical care for your child. Your child will need this important document for the rest of his/her life to enter day care or school, for employment, or for international travel.

Technical content reviewed by the Centers for Disease Control and Prevention, February 2012
 Content from: www.immunize.org/catg.d/p4060.pdf • Item #P4060 (2/12)

Immunization Action Coalition • 1573 Selby Ave. • St. Paul, MN 55104 • www.immunize.org • www.vaccineinformation.org



MOHAVE COUNTY DEPARTMENT OF PUBLIC HEALTH

NO ASIIS RECORD

Text reminder? Y/N

CHILD'S FIRST NAME:	MI:	LAST NAME:	CHILD'S SSN:	DATE OF BIRTH:	AGE:
ADDRESS:			APT #:	MALE	FEMALE
CITY:		STATE:	ZIP:	TELEPHONE:	
NAME OF GUARDIAN:			RELATIONSHIP:	Email:	
<input checked="" type="checkbox"/> (Check) the one that applies: <input type="checkbox"/> On AHCCCS, Medicaid, or CMDP <input type="checkbox"/> No Insurance <input type="checkbox"/> Native American or Alaskan Native <input type="checkbox"/> Underinsured <input type="checkbox"/> Kids Care <input type="checkbox"/> Insurance *Billing information needed below*				<input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Black <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other: _____	
Policy Holder Name _____		Policy Holder SSN _____ (for insurance verification only)			
<p><i>Do you plan to return to the Health Dept for this child's next immunizations?</i> Circle one Yes No</p> <p><i>How did you hear about our immunization clinic?</i></p> <p> <input type="checkbox"/> Received Postcard <input type="checkbox"/> Doctor Referral <input type="checkbox"/> Returning Patient <input type="checkbox"/> Phone Call <input type="checkbox"/> School Referral <input type="checkbox"/> Other _____ </p>					
<small>ASSIGNMENT OF BENEFITS: I hereby assign to the Health Department any insurance or other third-party benefits available for health care services provided to me. I understand that the County Health Department has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Mohave County Health Department, I agree to forward the County Health Department all health insurance and other third-party payments I receive for services rendered to me immediately upon receipt.</small>					
<small>I agree to allow the health care provider giving vaccinations consent to release information about all vaccinations given to the person for whom I am authorized to consent, to the Arizona State Immunization Information System (ASIIS), other health care providers and schools in order to avoid receiving unnecessary vaccinations and to provide information about which 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. If you do not want this immunization data entered into ASIIS, please initial here _____</small>					
<small>I have been given a copy and have read, or have had explained to me, the information in the "Important Information Statement(s)" for the disease(s) and vaccine(s) checked below. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccines requested, and ask that the vaccine(s) checked below be given to the person named above for whom I am authorized to make this request. I have received a copy of Mohave County Department of Public Health, Nursing Division, Notice of Privacy Practice.</small>					

*By signing below you are agreeing to all of the statements listed above.

Patient/Parent Signature _____

Printed Name _____

Date _____