Indiana Immunization Coalition (IIC) Screening Questionnaire – ENGLISH
6919 East 10th Street, Suite C2, Indianapolis, IN 46219

School:

Complete the Following for the Person Who is Being Vaccinated:

PATIENT Name: FIRST_____ MIDDLE_____ LAST_____

Birth Date:____/_____/_____ Age:_____ Sex: □ F □ M Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino

Race: (Check all that apply) □ American Indian/Alaskan Native □ Asian □ Black □Native Hawaiian/Pacific Islander □ White □ Unknown

Phone Number (_____) _____- _____ Email address: _____

Mailing Address:_____City:_____ State:_____ Zip:_____

Parent/Guardian Full Name:_____

Insurance Status (Check box)

□ NO INSURANCE

□ MEDICAID

Company:_____Medicaid #:_____□ Don't know

□ PRIVATE or COMMERCIAL INSURANCE (NOT MEDICAID)

Insurance Company:_____Insurance Policy ID:_____Group #_____(if one applies):

Policy Holder Name:_____Policy Holder Birth Date:__/__/____Policy Holder Relationship to Patient: _____

Questions for the Person Getting Vaccinated:	NO	YES
1. Is the person to be vaccinated sick today? If yes, what are their symptoms?	□	□
2. Does the person to be vaccinated have any allergies to medications, foods, a vaccine component or latex? Please list allergies:	□	□
3. Has the person to be vaccinated ever had a serious reaction to a vaccine in the past? If yes, please explain:	□	□
4. Has the person to be vaccinated ever had Guillian-Barre Syndrome (GBS)?	□	□
5. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia, or other blood disorders?	□	□
6. Does the person to be vaccinated have cancer, leukemia, AIDS or any other immune system problem?	□	□
7. Does the person to be vaccinated take cortisone, prednisone, other steroids, or anticancer drugs, or have you had x-ray treatments for cancer?	□	□
8. Has the person to be vaccinated had a seizure, brain, or other nervous system problem?	□	□
9. Does the person to be vaccinated smoke?	□	□
10. During the past year, has the person to be vaccinated received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?	□	□
11. For women: Is the person to be vaccinated pregnant or is there a chance they could become pregnant during the next month?	□	□
12. Has the person to be vaccinated received any vaccinations in the past 4 weeks?	□	□

By signing below, I consent to the use and disclosure of my or my child's personal health information for the purpose of health care operations, along with the assignment of all payments from the insurer listed above to VaxCare for the services rendered.

Consent for Use of Protected Health Information & Claims Assignment: I hereby consent to and acknowledge the receipt of a Notice of Privacy Practices regarding the use and disclosure of my personal health information for the purpose of health care operations, along with the assignment of all payment from the insurer listed above to VaxCare associated with the services contemplated herein. Vaccine Authorization: My signature on this form indicates that I have requested that the vaccine indicated below be administered to me or my dependent by a VaxCare representative. I relieve VacXare, the VaxCare partner, the administering person and personnel of any liability for any reactions that should occur. I unconditionally and irrevocably waive any right to a trial by jury, to the maximum extent allowed by law, for any claim or action arising out of or related to this service, and that any suck=h claim or action shall be determined solely on an individual basis through arbitration in accordance with Commercial Arbitration Rules of the American Arbitration Association.

Please sign on other side

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Neither I nor VaxCare shall be entitled to join or consolidate claims in arbitration by or against other individuals or entities, or arbitrate any claims as a representative member of a class or in private attorney general capacity. In the case of the occupational exposure, VaxCare has patient's permission for blood testing for patient and employee safety alike. I have read or have had explained to me the information from the Vaccine Information Statement(s) and understand the risks (including adverse reactions) and benefits of the vaccine(s). If consenting for another, I have the legal authority, based on my relationship to the individual indicated above, to consent to this vaccine(s) administration.

□ **I consent** to myself/my child being vaccinated with all recommended vaccinations that are due at this time. If I want to refuse any specific vaccine I will call 317-628-7116 or email: clinic@vaccinateindiana.org Vaccines that may be administered based on you/your child's vaccination record: DTaP, Tdap, Hepatitis A, Hepatitis B, HIB, Polio, Rotavirus, Pneumococcal, Influenza, MMR, Human Papilloma Virus, Meningitis, Varicella

□ **Electronic Signatures:** Electronic signatures are used for health records as a means of attestation of electronic health record entries, transcribed documents, and computer-generated documents. By checking this box and submitting by name and date on this form I understand that I am executing an electronic signature which is considered legally binding as a means to provide consent to the terms and conditions outlined on this form. It is VaxCare's policy to accept electronic signature in lieu of physical signature. This process operates within the secured infrastructure, ensuring integrity of process and minimizing risk of unauthorized activity in the design, use, and access of the electronic health record.

Signature: X_____ **Date:**_____

Parent/Guardian signature required if under 18 years old

CLINIC USE ONLY

VACCINE	VIS	MANUFACTURER /LOT # / EXP DATE	INJECTION SITE	Route
DTAP	4/01/20		□ LA □ RA	□ IM
DTAP/HEP B/IPV	4/01/20 8/15/19 10/30/19		□ LA □ RA	□ IM
DTAP/IPV	4/01/20 10/30/19		□ LA □ RA	□ IM
HEP A □ adult □ peds	7/20/16		□ LA □ RA	□ IM
HEP B □ adult □ peds	8/15/19		□ LA □ RA	□ IM
HIB	10/30/19		□ LA □ RA	□ IM
HPV9	10/30/19		□ LA □ RA	□ IM
Influenza	08/15/19		□ LA □ RA	□ IM
MCV4	8/15/19		□ LA □ RA	□ IM
MEN B	8/15/19		□ LA □ RA	□ IM
MMR	8/15/19		□ LA □ RA	□ SC
MMR/V	8/05/19		□ LA □ RA	□ SC
PCV-13	10/30/19		□ LA □ RA	□ IM
POLIO	10/30/19		□ LA □ RA	□ IM □ SC
PPSV23	10/30/19		□ LA □ RA	□ IM
ROTAVIRUS	10/30/19			□ PO
TDAP	4/01/20		□ LA □ RA	□ IM
VARICELLA	8/15/19		□ LA □ RA	□ SC
ZOSTER	10/30/19		□ LA □ RA	□ IM

VACCINATOR NAME AND CREDENTIALS: _____ **DATE:** _____

CHECKED OUT IN VAXCARE BY: _____ **DATE:** _____