Vaccination Registration Form

The following questions will help determine if there is any reason we should not give you (or your child) a vaccine. Answering “yes” to any question does not necessarily mean you (or your child) should not be vaccinated. It simply means additional questions must be asked. If a question is unclear, please ask your health care provider to help explain.

Patient information

First name | **Last name**

Suffix (optional) | **Date of birth** (MM/DD/YYYY) | **Age**

Parent/guardian first name

Contact information

Home address | **City** | **Zip code**

Mobile number | **Email address**

Gender

- ☐ Female
- ☐ Male
- ☐ Non-binary
- ☐ Prefer not to say

Hispanic, Latino, or Spanish origin

- ☐ Argentinian
- ☐ Colombian
- ☐ Costa Rican
- ☐ Cuban
- ☐ Guatemalan
- ☐ Honduran
- ☐ Hispanic, Latino/ Spanish origin
- ☐ Mexican, Mexican American, Chicano
- ☐ Nicaraguan
- ☐ Panamanian
- ☐ Peruvian
- ☐ Puerto Rican
- ☐ Salvadorian
- ☐ Other South American
- ☐ Other
- ☐ Not of Hispanic, Latino or Spanish origin
- ☐ Prefer not to say

Race/nationality (check all that apply)

- ☐ American Indian
- ☐ Asian Indian
- ☐ Bangladeshi
- ☐ Black or African American
- ☐ Cambodian
- ☐ Chinese
- ☐ Fijian
- ☐ Filipino
- ☐ Guamanian
- ☐ Hmong
- ☐ Indonesian
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Malaysian
- ☐ Pakistani
- ☐ Samoan
- ☐ Sri Lankan
- ☐ Taiwanese
- ☐ Thai
- ☐ Tongan
- ☐ Vietnamese
- ☐ White
- ☐ Other

Vaccinations requested (check all that apply)

Please check all the boxes for vaccinations that you or your child intend to receive.

- ☐ Chickenpox (varicella)
- ☐ COVID-19
- ☐ DTaP
- ☐ Flu
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ HPV
- ☐ Men B+ACWY
- ☐ Meningitis B
- ☐ Meningococcal (ACWY)
- ☐ MMR
- ☐ Mpox (vaccinia)
- ☐ Polio
- ☐ Tdap

Screening Questions	Yes/No
Does the patient have allergies to medications, gelatin, yeast, a vaccine component, or latex?	☐ Yes ☐ No
Has the patient ever had a serious reaction after receiving a vaccine?	☐ Yes ☐ No
Does the patient have a severe immune system problem such as cancer, leukemia, HIV/AIDS, or are they taking any medication that can affect the immune system such as prednisone, steroids, cancer treatments, or drugs to treat auto-immune diseases?	☐ Yes ☐ No
Does the patient have uncontrolled seizures or a neurologic condition that is getting progressively worse, or a history of arthus-type reaction after a dose of DTaP or Tdap?	☐ Yes ☐ No
Has the patient ever had Guillain-Barré syndrome (GBS)?	☐ Yes ☐ No
Has the patient ever been diagnosed with a heart condition (myocarditis or pericarditis) or have they had Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after an infection with the virus that causes COVID-19?	☐ Yes ☐ No
In the past year, has the patient received immune (gamma) globulin, blood/blood products, or an antiviral drug?	☐ Yes ☐ No
Is the patient on long-term aspirin therapy?	☐ Yes ☐ No
Is the patient pregnant?	☐ Yes ☐ No
Has the patient received any vaccinations in the past 4 weeks?	☐ Yes ☐ No
Is the patient 2-4 years old and been diagnosed with wheezing or asthma by a healthcare provider in the past 12 months?	☐ Yes ☐ No
Does the patient have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak?	☐ Yes ☐ No
Has the patient been treated with an anti-viral medication in the past 2-3 weeks (e.g., oseltamivir, zanamivir, peramivir, or baloxavir)?	☐ Yes ☐ No

Health insurance

Do you have health insurance? ☐ Yes ☐ No

If yes,

Insurance provider

Primary carrier's full name

Relationship with primary carrier

Policy number

I attest to the following

All boxes must be checked for the patient to be vaccinated:

☐ I have read and understand the Vaccine Information Statement(s) for the requested vaccine(s) and understand the risks and benefits. (VIS: https://www.immunize.org/vaccines/vis/about-vis/)

☐ I certify that, to the best of my knowledge, the information submitted in this application is true and accurate. I understand that all immunizations will be reported to the California Immunization Registries (CAIR2 or RIDE). My Turn will put information about the patient's vaccination into CAIR2 as required by California Health and Safety Code 120440. This information can be accessed by licensed health care providers and public health departments.

- CAIR2: https://www.cdph.ca.gov/Programs/CID/DCDC/CAIR/Pages/CAIR-updates-about.aspx
- RIDE: https://www.myhealthyfutures.org

Patient or parent/guardian signature

Date signed

Minor Consent Form

Minor consent

I declare that I am (must check one):

- [ ] **The parent of the minor patient.**
- [ ] **The legal guardian of the named minor patient.**
- [ ] **An emancipated minor at least 16 years of age.**
- [ ] **A person with authority to make healthcare decisions on behalf of the minor patient.**
  Describe legal relationship here: _____

I attest to the following

All boxes must be checked for the minor to be vaccinated:

- [ ] I GIVE CONSENT for the minor patient to receive the vaccine(s). [If you do NOT give consent, do not complete this form.]
- [ ] I understand that by providing my voluntary consent, the minor patient can receive the vaccine(s) with or without a parent or guardian being physically present at the vaccination appointment.
- [ ] I consent to and authorize all medically necessary treatment in the rare event that the minor patient has a reaction to the vaccine(s).

Parent/guardian information

Please write your full name

Email address (optional)

Mobile number

Address (Street number & name, City, State, Zip code)

By signing my name and today's date in the boxes below, I am providing consent for the minor patient to receive the requested vaccine(s) and certify that (1) I am authorized to provide this consent and (2) all of the information I have provided on this form is true and correct to the best of my knowledge.

Parent/guardian signature

Date signed

For staff use only

Please enter your name, date, clinic, and signature below. Then, enter the information for each vaccine that was administered.

Name _____ Signature _____

Date _____ Time _____ Clinic _____

Product _____ **Dose no.** _____ **Dose** (ML) _____ **Asset name** _____

Injection site: RA LA RL LL **Route:** IM SQ NAS

Product _____ **Dose no.** _____ **Dose** (ML) _____ **Asset name** _____

Injection site: RA LA RL LL **Route:** IM SQ NAS

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