Dignity Health
Chandler Regional Medical Center

Appointments: go to
www.dignityhealth.org/chandlerimmunizations
Or call 480-728-2004

Child Immunization Registration

Please complete all highlighted areas. Please read and complete all 4 pages.

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

CHECK ONE :

(0) _____Child is enrolled in **Kids Care.**
(1) _____ Child is enrolled in **AHCCCS**.
(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

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) recommended. 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 signature indicates my approval for the vaccines recommended to me on the vaccine administration form.

Signature of Parent/Guardian:	**Date:**

HIPAA Acknowledgement

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: _____

Acknowledgment Signature: _____ Date: _____

If form signed by anyone other than the patient:

Print Name:_____ Relationship:_____

Patient's Preferred Language/auxiliary Aid(s):

☐ ENGLISH ☐ OTHER: _____

If other selected, please complete the Interpreter Services Documentation Form.

Dignity Health Staff: _____Date: _____

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?	☐	☐	☐
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

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

www.immunize.org/catg.d/p4060.pdf • Item #P4060 (10/20)

Dignity Health
Chandler Regional Medical Center

CRMC Community Wellness
777 E Galveston St.
Chandler, Az. 85225

CHILD VACCINE ADMINISTRATION FORM

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

AGE:_____ ALLERGIES:_____

BELOW USE FOR STAFF ONLY

SCREENED BY:_____DATE OF ADMIN./VIS GIVEN:_____

*SPECIAL CONSIDERATIONS:*_____

☐ MULTI-VACCINE VIS GIVEN
EDITION DATE 07/24/23

Dtap	Pediarix	Pentacel	Dtap-IPV	Hep A	Hep B	Hib	HPV9	Flu	Covid-19
#	#	#	#	#	#	#	#		
	Dtap-IPV-HepB	Dtap-IPV/Hib				MERCK	MERCK		
LVL LD IM	LVL LD IM	LVL LD IM	LVL LD IM	RVL RD IM	LVL LD IM	LVL LD IM	RD IM	RD LD IM	RD LD IM
VIS EDIT. DATE	Dtap vis 8/6/21 IPV vis 8/6/21 HepB vis05/12/23	Dtap vis 8/6/21 IPV vis 8/6/21 Hib vis 8/6/21	DTaP vis 8/6/21, IPV vis 8/6/21	VIS EDIT. DATE	VIS EDIT. DATE	VIS EDIT. DATE	VIS EDIT. DATE	VIS EDIT. DATE	VIS EDIT. DATE
8/6/2021				10/15/21	5/12/23	8/6/21	8/6/21	8/6/21	10/17/2024
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 20	Rota	RSV Mab	Tdap	VAR	MMRV
#	#	#	#	#	#	ANTIBODY	#	#	#
		BEXSERO	MERCK		MERCK			MERCK	MERCK
LD			RVL RD			100MG		LVL LD	RVL RD
IM SQ	RD IM	LD IM	IM SQ	RVL RD IM	ORAL	RVL IM	LD IM	IM SQ	IM SQ
VIS EDIT. DATE	VIS EDIT. DATES	VIS EDIT. DATE	VIS EDIT. DATE	VIS EDIT. DATE	VIS EDIT. DATE	VIS EDIT. DATE	VIS EDIT. DATE	VIS EDIT. DATE	VIS EDIT. DATE
8/6/21	8/6/21	8/6/21	8/6/21	5/12/23	10/15/21	9/25/23	8/6/21	8/6/21	8/6/21
ACCEPT:	ACCEPT:	ACCEPT:	ACCEPT:	ACCEPT:	ACCEPT:	ACCEPT:	ACCEPT:	ACCEPT:	ACCEPT:
DECLINE:	DECLINE:	DECLINE:	DECLINE:	DECLINE:	DECLINE:	DECLINE:	DECLINE:	DECLINE:	DECLINE:

MANUFACTURER, LOT NUMBER	NAME/TITLE OF ADMINISTRATOR