Immunization Pre-registration Checklist

_____ **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:**

Mohave County Health Department
2001 College Dr. Suite 115
Lake Havasu City, AZ
OR

Fax: 928-453-0740

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

Mohave County
Department of Public Health
Count On Us

NO ASIIS RECORD ☐

Text reminder? Y / N

MOHAVE COUNTY DEPARTMENT OF PUBLIC HEALTH

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:

√ (Check) the one that applies:

☐ On AHCCCS, Medicaid, or CMDP ☐ No Insurance ☐ Native American or Alaskan Native

☐ Underinsured ☐ Kids Care ☐ Insurance ***Billing information needed below***

Policy Holder Name_____ **Policy Holder SSN**_____(for insurance verification only)

☐ White ☐ Hispanic

☐ Black ☐ Non-Hispanic

☐ Asian ☐ Pacific Islander

☐ Other:_____

Do you plan to return to the Health Dept for this child's next immunizations? Circle one ***Yes*** ***No***

How did you hear about our immunization clinic?

☐ Received Postcard ☐ Doctor Referral ☐ Returning Patient

☐ Phone Call ☐ School Referral ☐ Other_____

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.

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 _____

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.

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

Patient/Parent Signature_____ Printed Name_____ **Date**_____

Screening Questionnaire for Child and Teen Immunization

For parents/guardians: The following questions will help us determine which vaccines you 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?	☐	☐	☐
2.	Does the child have allergies to ANYTHING (medications, food, vaccines, or latex)?	☐	☐	☐
3.	Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
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?	☐	☐	☐
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?	☐	☐	☐
6.	If your child is a baby, have you ever been told he/she has had intussusception (bowel obstruction)?	☐	☐	☐
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.	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?	☐	☐	☐
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?	☐	☐	☐
11.	Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐	☐
12.	Has the child received *any* vaccinations in the past 4 weeks?	☐	☐	☐
13.	Does the child have a history of fainting?	☐	☐	☐
14.	Is the child currently taking *any* medications?	☐	☐	☐
15.	Has the child had chicken pox?	☐	☐	☐
16	Did you bring your child's immunization record card with you?	☐	☐	☐

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