Screening for Immunization
Screening and Consent Form (School Form)

Patient's Name: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

School Name: _____ City:_____

Medicaid number: _____ ☐ My Child does not have medical Insurance.

Insurance Company Name: _____ Group # _____

Policy Holder Name: _____Policy member ID # _____

Please circle the appropriate responses below (required):

Race: White / African American / Hispanic or Latino/ Native Hawaiian / Asian / Alaskan Native / Native American / Other	**Ethnicity:** Not Hispanic or Latino/ Hispanic or Latino	**Gender:** Female / Male

Screening Checklist for Contraindications (Required)	**YES**	**NO**
Is the child sick today?		
Does the child have allergies to medications, food, a vaccine component, or latex?		
Has the child had a serious reaction to a vaccine in the past?		
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?		
Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?		
Does the child or a family member have cancer, leukemia, HIV/AIDS, or any other immune system problems?		
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?		
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?		
Is the child/teen pregnant or is there a chance she could become pregnant during the next month?		
Has the child received vaccinations in the past 4 weeks?		

I acknowledge that the patient's medical information provided above is correct. I have been given a copy of the Vaccine Information Statement for the vaccines indicated below and the NOTICE of PRIVACY POLICY FORM. I understand the benefits and risk of the vaccines that will be given to the patient. Additional information can be found at: https://www.cdc.gov/vaccines/schedules/ . I understand that participation and receipt of the vaccine(s) through this program is completely voluntary. By signing below, I attest that I am authorized to consent on behalf of the patient and hereby give permission for the patient listed above to receive the vaccines circled below with the understanding that immunization information will be entered into the Idaho Immunization Reminder Information System (IRIS). I understand Idaho IRIS is an opt-out program and I may decline to have information regarding the patient entered into the registry.

I understand my child will receive the following circled vaccinations:
DTaP / Flu / Hep A / Hep B / HPV / Meningitis / MMR / Polio / Tdap / Varicella

Name of Parent or Guardian **Date** **Time**

Signature of Parent of Guardian **Relationship to Patient**