CHI Franciscan Health
Our best care. Your best health.™

Child/Adolescent Immunization Questionnaire

Franciscan Health System Children's Immunization Program
1717 South J Street, Tacoma, WA 98405 253-382-8572

By signing below, I acknowledge that I have been given a copy and have read, or have had explained to me the information in the Vaccine Information Statement(s). I have had a chance to ask questions that were answered to my satisfaction. I understand the risks and benefits of the vaccine(s). I request that the vaccine(s) indicated be given to the child/adolescent named below for whom I am the parent or legal guardian, for whom I am authorized to make this request. I understand my child's immunization information will be entered into an electronic database that can be shared with other providers/school personal. Records may be entered into school database. A copy of Franciscan Health System's Notice of Privacy Practice (NNP) is available to you.

Parent/Guardian Name: (***print***) _____ Signature: _____ Date:_____

Child's Name: _____ Birth Date: _____ Age:_____ ☐ M ☐ F
(First) (Middle) (Last)

Address: _____
(Mailing Address) (City) (State) (Zip Code)

Phone: _____ Cell Phone: _____ Medical Provider (Physician/Clinic): ☐ Yes ☐ No

Child: ☐ **Uninsured**-No Insurance ☐ **State Supported Insurance**-Medicaid, Coupons, Healthy Options, Molina, Basic Health Plan
☐ **Under Insured**- Insurance doesn't cover immunizations ☐ **Insurance**-Donations appreciated

Child: ☐ **American Indian** ☐ **Alaska Native**

1.	Is your child sick today?	☐ Yes ☐ No
2.	Has your child ever fainted or been very fearful of shots or blood tests?	☐ Yes ☐ No
3.	Does your child have or has ever had seizures, neurological problems, or Guillain-Barre Syndrome?	☐ Yes ☐ No
4.	Is your child allergic to **eggs, yeast, gelatin, any vaccine, vaccine component or Latex?**	☐ Yes ☐ No
5.	Is your child allergic to anything else? If yes, please list:	☐ Yes ☐ No
6.	Has your child ever had a serious reaction after receiving a vaccine?	☐ Yes ☐ No
7.	Does your child have any immune system problems (for example cancer, AIDS, leukemia, or take cortisone prednisone or other steroids?)	☐ Yes ☐ No
8.	Does your child have any chronic medical conditions such as **asthma, diabetes, digestive problems**?	☐ Yes ☐ No
9.	Does any person who lives with or has close contact with your child, have any immune system problems such as cancer, AIDS, leukemia, or high dose steroid use?	☐ Yes ☐ No
10.	During the past year has your child received a transfusion of blood or plasma, or been given a medicine called immune globulin?	☐ Yes ☐ No
11.	Has your child received any other vaccines within the last four weeks?	☐ Yes ☐ No
12.	**For females only**: is your adolescent pregnant or at risk for becoming pregnant in the next three months?	☐ Yes ☐ No
13.	Has your child had the disease chicken pox? If yes, when: _____	☐ Yes ☐ No

If your child does not have a medical provider would you like referral information? ☐ Yes
If your child does not have medical insurance would you like referral information? ☐ Yes

Thank you for your patience at busy times

Clinics are funded in part by Tacoma Pierce County Health Department
Clinics held in Lakewood are funded in part by City of Lakewood

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FREE Immunizations at School

Children 11 years of age and older receiving vaccines will need:

- **Both side of this form must be COMPLETELY filled out.** All questions must be answered
- **Parent signatures required on both sides of this form**
- **Circle yes and initial each vaccine requested** (see box below)

I, _____ request that _____ receive:
(Parent/Guardian) (child's name)

PLEASE CIRCLE YES AND INITIAL ALL REQUESTED VACCINES			
Tdap 1 dose is required ▶ **Child must be 11 years old** ◀	**Yes** **Initial:** ----------	**Varicella (Chicken Pox)** **2-dose series**	**Yes** **Initial:** ----------
Hepatitis A **2 dose series**, 2nd dose due in 6 months	**Yes** **Initial:** ----------	**Influenza** **Yearly**, Given when vaccine is available	**Yes** **Initial:** ----------
Meningococcal **2 dose series**, 2nd dose due: • Age 16 if 1st dose administered at 11-12 years of age • Age 16-18 if the 1st dose administered at 13-15 years of age • If 1st dose administered at or after age 16, no booster dose required	**Yes** **Initial:** ----------	**HPV** **3 dose series**, 2nd dose due 2 months after 1st dose, 3rd dose due 6 months after 1st dose.	**Yes** **Initial:** ----------
		Other* **Write in vaccine(s)** if your child is not up to date : • ---------- • ----------	**Yes** **Initial:** ----------
Your child will be given an immunization record of vaccines received. *Check backpacks!*			

Note: Please make sure that the following are completed on these forms:

- **CIRCLE Yes** for all requested vaccines above
- **SIGNATURE or INITIALS** of Parent/Guardian on **BOTH SIDES**
- **ALL QUESTIONS** are answered with a **YES** or **NO** on Questionnaire form

RETURN THIS FORM TO YOUR SCHOOL NURSE BEFORE THE CLINIC DATE