Wahiawā Health

302 California Ave Suite # 106 Wahiawa, Hi 96786

Name: Last:	First:	Middle Initial:	
Date of Birth: Month:	Day:	Year:	**Mobile Phone #:**
Address:			**Apt/Room #:**
City:	**State:**		**Zip:**

SEX (gender assigned at birth)	**Race**	**Ethnicity**
☐ Female ☐ Male	☐ American Indian or Alaska Native ☐ Asian or Other ☐ Black or African American ☐ Native Hawaiian or Other ☐ Pacific Islander or Other ☐ White ☐ Other Non-White	☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Unknown

Primary Insurance Carrier ID#: _____GROUP#: _____
Insurance Company: _____Insurance Company Phone Number#: _____
Insured's Name: _____Relationship: _____Insured's DOB_____

Patient Eligibility		
__ Medicaid	__ No Health Insurance	__Fully Insured

Vaccine Documentation/Consent Form

I have been offered a copy of the Vaccine Information Statement(s) (VIS) checked below. I have read, had explained to me, and understand the information in the VIS(s). I ask that the vaccine(s) checked below be given to me or to the person named below for whom I am authorized to make this request. I consent to the inclusion of this immunization data in the Hawaii Immunization Registry for myself or on behalf of the person named below.

__DT __DTaP __Tdap __Td __HepA __HepB __Hib __HPV __Influenza __Meningococcal
__MMR __PCV7/13 __PPV23 __Polio/IPV __Rotavirus __Varicella __Other_____

Parent/Guardian Signature: _____
Date: _____

IMMUNIZATION SCREENING QUESTIONNAIRE	YES	NO
1. Is the person to be vaccinated currently sick or experiencing a high fever?		
2. Has the person to be vaccinated had a serious reaction to a vaccine in the past?		
3. Does the person to be vaccinated have any allergies that produce a severe (anaphylactic) reaction? If so, please list:		
4. Has the person to be vaccinated had a seizure or other neurological problem?		
5. Does the person to be vaccinated have any medical problems that make it hard for him/her to fight infection?		
6. Does the person to be vaccinated have close, regular contact with someone with a weakened immune system?		
7. Is the person taking cortisone, prednisone, other steroids, or anti-cancer drugs, or had x-ray treatments?		
8. Has the person to be vaccinated received blood, plasma, or immune globulin in the past twelve months?		

Name: _____ Age: _____ DOB:_____

PROVIDER INFORMATION					
Vaccine Provider:			Clinic Site:		
Street Address:	State:	Zip Code:	Street Address:	State:	Zip Code:

(Circle the appropriate vaccine, dose, extremity, site, route, and enter the manufacturer, lot #, and expiration date.)

FOR CLINICAL USE ONLY							
VACCINE	**DOSE**	**EXT**	**SITE**	**ROUTE**	**VIS DATE**	**MANUFACTURER LOT #**	**EXP DATE**
DTap DT Td Tdap	0.5 ml 1 2 3 4 5 6	RT LT	Deltoid Vastus Lat	IM			
DTaP/IPV	0.5 mL 5th DTap-4th IPV	RT LT	Deltoid Vastus Lat	IM			
DTaP/HepB/IPV	0.5 mL 1 2 3	RT LT	Deltoid Vastus Lat	IM			
DTaP/Hib/IPV	0.5 mL 1 2 3 4	RT LT	Deltoid Vastus Lat	IM			
DTaP/Hib	0.5 mL 4	RT LT	Deltoid Vastus Lat	IM			
Hep A	0.5 mL 1.0mL 1 2	RT LT	Deltoid Vastus Lat	IM			
Hep B	0.5 mL 1.0mL 1 2 3	RT LT	Deltoid Vastus Lat	IM			
Hep B/Hib	0.5 mL 1 2 3	RT LT	Deltoid Vastus Lat	IM			
Hib	0.5 mL 1 2 3 4	RT LT	Deltoid Vastus Lat	IM			
HPV	0.5 mL 1 2 3	RT LT	Deltoid	IM			
Influenza LAIV TIV	0.1mL 0.2mL 0.25mL 0.50mL 1 2	RT LT	Forearm Deltoid Vastus Lat	Intradermal Intranasal IM			
MCV4	0.5mL 1 2	RT LT	Deltoid	IM			
MMR	0.5mL 1 2	RT LT	Upper Arm Thigh	SC			
MMR-V	0.5mL 1 2	RT LT	Upper Arm Thigh	SC			
PCV7/13	0.5mL 1 2 3 4	RT LT	Deltoid Vastus Lat	IM			
Polio/IPV	0.5mL 1 2 3 4 5	RT LT	Upper Arm Thigh	IM SC			
PPV23	0.5mL 1 2	RT LT	Upper Arm Deltoid Vastus Lat	SC IM			
Rotavirus	2.0mL 1 2	RT LT	By Mouth	Oral			
Varicella	0.5mL 1 2	RT LT	Upper Arm Thigh	SC			
Other							

_____ _____

Signature and Title of Vaccine Administrator Date