Immunization Client Information Form

Notes:

Date: **SAIRS ID #:** **School Grade Level:** (If applicable)

Last Name: **First Name:** **Middle Name:**

Gender: **Date of Birth:** **Other Names Used (Alias)**

Does this client have private health insurance?

☐ No ☐ Yes: Name of Insurance: _____

Is this client enrolled in Medicaid or CHIP?

☐ Medicaid ☐ CHIP ☐ NONE

Preferred Language:

☐ English ☐ Spanish ☐ Other _____

Has this client ever had chicken pox?

☐ No ☐ Yes: Date of Illness: _____

Refugee Status Card #: (If applicable)

Contact Information

Mailing Address: **Unit/Apt #:**

City: **State:** **Zip Code:** **County:**

How long has this client lived at this address?

Physical Address: (If different from address above)

Phone Number: ( )

☐ Home ☐ Cell ☐ Work ☐ Other

Alternate Number: ( )

☐ Home ☐ Cell ☐ Work ☐ Other

Email Address:

Demographic Information

Race: (You may check more than one.)

☐ Alaskan Native ☐ American Indian ☐ Asian

☐ Black/African American ☐ Pacific Islander ☐ White

Hispanic?

☐ Yes

☐ No

Country of Birth:

☐ USA

☐ Other _____

Mother's Last Name: **Mother's First Name:** **Mother's Maiden Name:**

If you are completing this form for a child, please fill in your information below:

Last Name: **First Name:** **Relationship to Child:**

For Office Use Only:

☐ DTaP/ DT/ Td/ Tdap ☐ Hep B ☐ Hib ☐ PCV13/ PPV23 ☐ Varicella ☐ Influenza

☐ DTaP-IPV/Hib (Pentacel) ☐ Hep A ☐ Rotavirus ☐ Polio-IPV ☐ MMR ☐ Other _____

☐ DTaP-IPV (Kinrix)

☐ DTaP-HepB-IPV (Pediarix) ☐ Hep A-HepB (Twinrix) ☐ MCV4/ MCV4O ☐ HPV4/ HPV2