California Immunization Registry (CAIR)

VISIT #: _____

I agree to allow my or my child's immunization record/TB test record to be shared with other healthcare providers, agencies, or schools in the California Immunization Registry.*

Client Name (Please PRINT) (First, Middle initial, Last)	Date of Birth	Gender	Mother's First Name & Maiden Name (for identification purposes)	Internal use only: CAIR #
_____	___/___/___	M F	_____	_____
_____	___/___/___	M F	_____	_____
_____	___/___/___	M F	_____ _____	_____
_____	___/___/___	M F	_____ _____	_____
_____	___/___/___	M F	_____ _____	_____

Mailing Address: _____ Phone: _____

City, State, ZIP: _____

I have received (or been offered) the Tehama County Health Services Agency (TCHSA) **Notice of Privacy Practices** on this date. The TCHSA Notice of Privacy Practices provides information about how TCHSA may use and disclose your protected health information. TCHSA encourages you to read it in full.

Client(s) Signature OR parent/guardian's signature: ☐ SELF ☐ PARENT/GUARDIAN Date: _____

X_____ X_____ X_____

If Client is a minor, please PRINT parent/guardian's name:

_____

(First, Middle Initial, Last)

☐ I decline to allow my or my child's immunization record/tuberculosis (TB) screening test record to be shared with other health care providers, agencies, or schools in the California Immunization Registry. *

*Note: The immunization record/TB Tests may still be recorded in the registry for use by this office. By law, public health officials can also access immunization/TB Test records in the case of a public health emergency

ENTERED
_____

Please check the following that apply:

- ☐ Medi-Cal OR CHDP eligible
- ☐ No Insurance
- ☐ American Indian OR Alaskan Native
- ☐ Private Insurance - does not cover vaccines
- ☐ Private Insurance
- ☐ Medicare

The following questions will help us determine which vaccines may be given to the client today. If you answer "yes" to any question, it does not necessarily mean that the client should not be vaccinated; it just means that the nurse will ask additional questions. If you are the client, please answer for yourself. If your child is the client, please answer for them.
If a question is not clear, please ask your healthcare provider to explain it.

If completing this section for more than one individual, please write the <u>name of the client</u> in the box when marking "yes" to any question.

1. If the client is under the age of eighteen, are you the parent or legal guardian? (If you answered NO, you must have a note from the patient's parent.)	Yes No
2. Is the client sick or running a high fever today?	Yes No
3. Does the client have allergies to medications, food, a vaccine component, or latex?	Yes No
4. Has the client ever had a serious reaction after receiving a vaccination?	Yes No
5. Does the client have a health problem with lung, heart, kidney, or metabolic disease (e.g. diabetes), asthma, or a blood disorder or on long-term aspirin therapy?	Yes No
6. Has the client, or a sibling, had a seizure, brain disorder, or nervous system problem?	Yes No
7. Does the client have cancer, leukemia, AIDS or any other immune system problems?	Yes No
8. In the past 3 months, has the client or anyone in their household taken cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?	Yes No
9. In the past year, has the client received a blood transfusion, blood products, or been given immune (gamma) globulin or an antiviral drug?	Yes No
10. Is there a chance that the client is pregnant or planning on becoming pregnant during the next month?	Yes No
11. Has the client received a vaccination in the past 4 weeks?	Yes No
12. ***<u>For clients less than 1 year old</u>***; have you ever been told that he/she has had intussusception?	Yes No