



PLEASE PRINT

High School _____ Grade _____

LAST Name _____

FIRST Name _____

Male [] Female [] Birthdate ____/____/____ Age _____

Name of Parent/Guardian _____

Screening Questions	
1. Is the child sick today?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Does the child have allergies to medications, food, or any vaccine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Has the child had a serious reaction to a vaccine in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has the child had a seizure or a brain problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Does the child, or any person who lives with or takes care of the child, have cancer, leukemia, AIDS, or any other immune system problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Has the child taken cortisone shots, prednisone, other steroids, or anti-cancer drugs, or had x-ray treatments in the past 3 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Has the child received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Is the child pregnant or is there a chance she could become pregnant in the next 3 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Has the child received any vaccinations in the past 4 weeks?	<input type="checkbox"/> Yes <input type="checkbox"/> No

I give my permission to enroll me or my child and to **transfer** my or my child's immunization records into the **Idaho Immunization Reminder Information System (IRIS)** to ensure that this vaccination record is available to me, my or my child's health care providers, child care providers, and schools. I understand I may be asked for information that will help ensure my or my child's records are accurate and will not be confused with another person's records, such as: mother's maiden name, telephone number, gender, and child's eligibility for free vaccine. I authorize inclusion of all information into **IRIS**.

Street Address _____ City, State, Zip _____ Phone Number _____

Relationship to Child (if applicable) _____ Mothers Maiden Name _____ Signature _____ Date _____

Vaccine	Date Given	Manufacturer & Lot	Site	Administered By	VIS
MMR					03/13/08
Hep B					07/18/07
Hep A					03/21/06
Tdap					11/18/08
IPV					01/01/00
MCV-4					01/28/08