Patient Registration Form

(Please Print Clearly)

Immunization CLINIC
Be wise, test and immunize

NAME: _____
Last First M.I.

EMAIL: _____ **BIRTH DATE:**____/_____/____

SEX: □ Male □ Female **RACE/ETHNIC:** □ White □ African-Amer. □ Asian □ Hispanic/Latino □ Other

ADDRESS:_____
No. Street Apt. City State Zip

PHONE: □HOME □OFFICE ( ) _____-_____ **CELL:** (_) _____-_____

EMERGENCY CONTACT _____ _____ _____
Name Relationship Phone

ALLERGIES to foods or medicines: _____

HOW DID YOU LEARN ABOUT IMU: (CHECK ALL THAT APPLY**)**

□ I have been here before □ Referred by my doctor/clinic (name, phone) _____

□ Web search □ Referred by my school/employer (name)_____

□ Ad □ Referred by my friend/family/other (name) _____

Consent for Medical Care, Record Keeping, Privacy Notice, and Payment Responsibility

I, as the client/patient, agree to receive care from a health care provider at the IMU Southwest, Immunization Clinic. I give consent for examination, immunization, blood or skin testing, medical advice, and other services from my IMU provider. (2) I understand that it is my responsibility to pay for services received. (3) I acknowledge that I have had the opportunity to read or receive a copy of the "Notice of Privacy Practices" (posted). (4) I understand that IMU email transmission may not be secure against unauthorized disclosure, and I hereby authorize that IMU may send my health information to me via unsecure email, but only upon my specific request to receive such information by email. (5) The IMU Southwest Clinic will keep this record in you or your child's medical file. It records what vaccine(s) and/or test(s) were given, the date when the vaccine(s) and/or test(s) were given, the name of the company that made the vaccine(s) and/or test(s), the lot number of the vaccine(s) and/or test(s), and the address where the vaccine(s) and/or test(s) were administered. (6) By signing the form below, you hereby freely and voluntarily give your permission and are requesting that the vaccine(s) and/or test(s) indicated by your signature(s) below be given to you or the person named below for whom you are authorized to make this request. (7) I understand the risks and benefits of the test/vaccine being given to me and have the opportunity to read The Vaccine Information Sheet "VIS" on each vaccine, or a "Subject Information" pamphlet on each test, as stated by law, for me to read BEFORE I receive your shots and/or test(s). Your signature below indicates that you have read, or have had the information explained to you and that you understand the benefits and risks of each vaccine administered. You hereby release and agree to hold harmless The IMU Southwest Clinic, its Officers, and Employees for any and all liability, of any kind or nature whatsoever, which might arise out of or result from any vaccine(s) and/or test(s) administered to you or your child.

Signed: _____ Date:_____

If client is a minor:

Print name of parent/ guardian: _____

Signature of parent/guardian:_____ Date: _____

For Clinic/Office Use Only Vaccine Information Statements (VISs) as of August 6, 2016

Varicella 3/13/08	DTap 5/17/07	Hib 2/4/14	Hepatitis A 7/20/16	HPV Ceravix 5/3/11	Influenza 8/7/15
Polio 7/20/16	PCV 13 11/5/15	MMR 4/20/12	Hepatitis B 7/20/16	HPV9 Gardasil 3/31/16	Shingles 10/6/09
Rabies 10/6/09	PPSV 4/24/15	MMRV 5/21/10	Meningococcal 10/14/11	Japanese Enceph 1/24/14	Typhoid 5/29/12
Td/Tdap 5/9/13 2/4/14	Yellow Fever 3/30/11		Multi-Vaccine 11/5/15	Rotavirus 4/15/15	

SCREENING QUESTIONAIRE FOR INTERNATIONAL TRAVEL

Medical History of: (your name) _____
Occupation (This is for CDC data purposes): _____

Should we send a copy of your Immunization record to your Primary Physician? Yes ___No ___

If yes, give us as much information as you know on your physician:

Primary Physician: _____ Telephone: _____
Office Address: _____
City: _____ State:_____ Zip Code: _____

Destination of Travel:

1. Where are you going? [Please list countries and areas within countries, rural vs. urban]: _____

2. Date of Departure:_____ Date of Return:_____

3. Purpose of Travel (This is for CDC data purposes): Business ___Pleasure ___Mission___ Study ___Service ___

4. Name of Church or Business Affiliation for the trip: _____

Health History

Allergies: _____
Weight: _____ Height: _____

Medications: [*Please list all medications currently being taken*]

Prescription: _____

Non Prescription: _____

Medical Conditions: _____

Previous Surgery(s): _____

Check if you have present or past history of the following: Nightmares □ Psoriasis□ Psychiatric Disorders/Depression □ Seizures/Epilepsy □ Stomach/Colon□ Problems

I verify that the above information is complete and correct to the best of my knowledge:

Patient Signature: _____ Date: _____
Reviewed by:_____ Date:_____