



SUMMIT COUNTY PUBLIC HEALTH REGISTRATION FORM

www.scphoh.org

1867 West Market Street ♦ Akron, Ohio 44313-6901
Phone: (330) 923-4891 ♦ Toll-free: 1 (877) 687-0002 ♦ Fax: 330-752-7925

Today's Date: \_\_\_\_\_

Reason for Visit:

- Received a post card, Received a phone call, New patient, Return visit

How did you hear about us:

Patient Information:

Last Name, First Name, Middle Initial, Address, City, State, Zip, Home Phone, Cell Phone, E-Mail Address, Date of Birth, Age, Gender, Social Security Number, Marital Status, Ethnicity, Emergency Contact, Doctor's Name, Specialty Doctor's Name, Dentist's Name

Insurance information

- I have insurance coverage, Does your insurance cover immunizations?, I have no insurance coverage, Would you like a Medicaid application

Primary Insurance Coverage

Name and Address of insurance company, Effective date, Name of person on card, SS #, Birth date, ID # on card, Group # on card

Secondary Insurance Coverage

Name and Address of insurance company, Effective date, Name of person on card, SS #, Birth date, ID # on card, Group # on card

Please check this box if you would like information about other resources or programs offered in our community.

Thank you for visiting our clinic!

I acknowledge that I have been offered a copy of the Notice of Privacy Practices

Client or Guardian Signature

Date



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**PATIENT CONTACT DIRECTIVES**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone Number (Home/Cell) \_\_\_\_\_ Language: \_\_\_\_\_

**Patient Privacy Directives**

**In our efforts to comply with the health Insurance Portability and Accountability Act (HIPAA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers.**

**Do we have permission to:**

Contact you on the number listed above to discuss appointments, treatment or test results?

Yes  No

Leave a message regarding appointments on the number listed above?

Yes  No

Would you like us to text health information to you? (Encoded STD test results only)

Yes  No

\*Would you like us to share health or payment information with close friends or relatives, directly involved with your care?

Yes  No

If yes:

\*Please provide us with a name and phone number that we may leave messages regarding **appointments**:  
Name: \_\_\_\_\_ Number: \_\_\_\_\_ (Home/Cell//Email)

Relationship to Patient \_\_\_\_\_

\*Please provide us with a name and phone number that we may leave a message regarding **treatments and/or test results**.

Name: \_\_\_\_\_ Number: \_\_\_\_\_ (Home/Cell/Email)

Relationship to Patient \_\_\_\_\_

\*Do you have any other specific instructions/requests about how we should communicate with you or others about your appointments, treatment, or test results? \_\_\_\_\_

**I acknowledge that all information above is accurate.** You must inform us **in writing** of any changes in your directives.

Signature \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_



PATIENT: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

VITAL SIGNS: REFERRED TO PCP \_\_\_\_\_

WT: \_\_\_\_\_ TEMP: \_\_\_\_\_ BP: \_\_\_\_\_ / \_\_\_\_\_

PULSE: \_\_\_\_\_ RESPIRATIONS: \_\_\_\_\_

# Screening Checklist for Contraindications to Vaccines for Adults

**For patients:** The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

Don't  
Yes No Know

- |  |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|
| 1. Are you sick today?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have allergies to medications, food, a vaccine component, or latex?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had a serious reaction after receiving a vaccination?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder.   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs: drugs for the treatment of rheumatoid arthritis, Crohn's disease or psoriasis: or have you had radiation treatments? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you had a seizure or a brain or other nervous system problem?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. For women: Are you pregnant or is there a chance you could become Pregnant during the next month?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you received vaccinations in the past 4 weeks?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

11. List all of the prescriptions and over the counter medications you are taking and why:  
\_\_\_\_\_  
\_\_\_\_\_

Form completed by: \_\_\_\_\_ Date: \_\_\_\_\_

Form reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

Did you bring your immunization record with you?  Yes  No

# Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
month day year

**For patients:** The following questions will help us determine which vaccines you may be given today. If you answer “yes” to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Are you sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have allergies to medications, food, a vaccine component, or latex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a serious reaction after receiving a vaccination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you had a seizure or a brain or other nervous system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you received any vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FORM COMPLETED BY \_\_\_\_\_ DATE \_\_\_\_\_

FORM REVIEWED BY \_\_\_\_\_ DATE \_\_\_\_\_

**Did you bring your immunization record card with you?**      yes       no

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

# Information for Healthcare Professionals about the Screening Checklist for Contraindications to Vaccines for Adults

*Are you interested in knowing why we included a certain question on the screening checklist? If so, read the information below. If you want to find out even more, consult the references listed at the end.*

## 1. Are you sick today? [all vaccines]

There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events.<sup>1</sup> However, as a precaution with moderate or severe acute illness, all vaccines should be delayed until the illness has improved. Mild illnesses (such as upper respiratory infections or diarrhea) are NOT contraindications to vaccination. Do not withhold vaccination if a person is taking antibiotics.

## 2. Do you have allergies to medications, food, a vaccine component, or latex? [all vaccines]

An anaphylactic reaction to latex is a contraindication to vaccines that contain latex as a component or as part of the packaging (e.g., vial stoppers, prefilled syringe plungers, prefilled syringe caps). If a person has anaphylaxis after eating gelatin, do not administer vaccines containing gelatin. A local reaction to a prior vaccine dose or vaccine component, including latex, is not a contraindication to a subsequent dose or vaccine containing that component. For information on vaccines supplied in vials or syringes containing latex, see reference 2; for an extensive list of vaccine components, see reference 3.

People with egg allergy of any severity can receive any recommended influenza vaccine (i.e., any IIV or RIV) that is otherwise appropriate for the patient's age. For people with a history of severe allergic reaction to egg involving any symptom other than hives (e.g., angioedema, respiratory distress), or who required epinephrine or another emergency medical intervention, the vaccine should be administered in a medical setting, such as a clinic, health department, or physician office. Vaccine administration should be supervised by a healthcare provider who is able to recognize and manage severe allergic conditions.<sup>4</sup>

## 3. Have you ever had a serious reaction after receiving a vaccination? [all vaccines]

History of anaphylactic reaction (see question 2) to a previous dose of vaccine or vaccine component is a contraindication for subsequent doses.<sup>1</sup> Under normal circumstances, vaccines are deferred when a precaution is present. However, situations may arise when the benefit outweighs the risk (e.g., during a community pertussis outbreak).

## 4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder? [LAIV]

The safety of intranasal live attenuated influenza vaccine (LAIV) in people with these conditions has not been established. These conditions, including asthma in adults, should be considered precautions for the use of LAIV.

## 5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? [LAIV, MMR, VAR, ZOS]

Live virus vaccines (e.g., LAIV, measles-mumps-rubella [MMR], varicella [VAR], zoster [ZOS]) are usually contraindicated in immunocompromised people. However, there are exceptions. For example, MMR vaccine is recommended and varicella vaccine should be considered for adults with CD4+ T-lymphocyte counts of greater than or equal to 200 cells/ $\mu$ L. Immunosuppressed people should not receive LAIV. For details, consult the ACIP recommendations.<sup>4,5,6</sup>

## 6. In the past 3 months, have you taken medications that affect your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments? [LAIV, MMR, VAR, ZOS]

Live virus vaccines (e.g., LAIV, MMR, VAR, ZOS) should be postponed until after chemotherapy or long-term high-dose steroid therapy has ended. For details and length of time to postpone, consult the ACIP statement.<sup>1,5</sup> Some immune mediator and immune modulator drugs (especially the antitumor-necrosis factor agents adalimumab, infliximab, and etanercept) may be immunosuppressive. The use of live vaccines should be avoided in persons taking these drugs (MMWR 2011;60 [RR-2]:23). To find specific vaccination schedules for stem cell transplant (bone marrow transplant) patients, see reference 7. LAIV can be given only to healthy non-pregnant people ages 2 through 49 years.

**NOTE:** Live attenuated influenza vaccine (LAIV4; FluMist), is not recommended by CDC's Advisory Committee on Immunization Practices for use in the U.S. during the 2016–17 influenza season. Because LAIV4 is still a licensed vaccine that might be available and that some providers might elect to use, for informational purposes, reference is made to previous recommendations for its use.

## 7. Have you had a seizure or a brain or other nervous system problem? [influenza, Td/Tdap]

Tdap is contraindicated in people who have a history of encephalopathy within 7 days following DTP/DTaP given before age 7 years. An unstable progressive neurologic problem is a precaution to the use of Tdap. For people with stable neurologic disorders (including seizures) unrelated to vaccination, or for people with a family history of seizure, vaccinate as usual. A history of Guillain-Barré syndrome (GBS) is a consideration with the following: 1) Td/Tdap: if GBS has occurred within 6 weeks of a tetanus-containing vaccine and decision is made to continue vaccination, give Tdap instead of Td if no history of prior Tdap; 2) Influenza vaccine (IIV/LAIV): if GBS has occurred within 6 weeks of a prior influenza vaccine, vaccinate with IIV if at increased risk for severe influenza complications.

## 8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? [LAIV, MMR, VAR, ZOS]

Certain live virus vaccines (e.g., LAIV, MMR, VAR, ZOS) may need to be deferred, depending on several variables. Consult the most current ACIP recommendations for current information on intervals between antiviral drugs, immune globulin or blood product administration and live virus vaccines.<sup>1</sup>

## 9. For women: Are you pregnant or is there a chance you could become pregnant during the next month? [HPV, IPV, MMR, LAIV, VAR, ZOS]

Live virus vaccines (e.g., MMR, VAR, ZOS, LAIV) are contraindicated one month before and during pregnancy because of the theoretical risk of virus transmission to the fetus. Sexually active women in their childbearing years who receive live virus vaccines should be instructed to practice careful contraception for one month following receipt of the vaccine. On theoretical grounds, inactivated poliovirus vaccine should not be given during pregnancy; however, it may be given if risk of exposure is imminent and immediate protection is needed (e.g., travel to endemic areas). Inactivated influenza vaccine and Tdap are both recommended during pregnancy. Both vaccines may be given at any time during pregnancy but the preferred time for Tdap administration is at 27–36 weeks' gestation. HPV vaccine is not recommended during pregnancy.<sup>1,4,5,6,8,9</sup>

## 10. Have you received any vaccinations in the past 4 weeks? [LAIV, MMR, VAR, yellow fever, ZOS]

People who were given either LAIV or an injectable live virus vaccine (e.g., MMR, VAR, ZOS, yellow fever) should wait 28 days before receiving another vaccination of this type. Inactivated vaccines may be given at any spacing interval if they are not administered simultaneously.

## REFERENCES

1. CDC. General recommendations on immunization, at [www.cdc.gov/mmwr/pdf/rr/rr6002.pdf](http://www.cdc.gov/mmwr/pdf/rr/rr6002.pdf).
2. Latex in Vaccine Packaging: [www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/latex-table.pdf](http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/latex-table.pdf).
3. Table of Vaccine Components: [www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/exipient-table-2.pdf](http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/exipient-table-2.pdf).
4. CDC. Prevention and control of seasonal influenza with vaccines: Recommendations of the Advisory Committee on Immunization Practices – United States, 2016–17 influenza season at [www.cdc.gov/mmwr/volumes/pdf/65/rr/pdfs/rr6505.pdf](http://www.cdc.gov/mmwr/volumes/pdf/65/rr/pdfs/rr6505.pdf), pages 1–56.
5. CDC. Measles, mumps, and rubella – vaccine use and strategies for elimination of measles, rubella, and congenital rubella syndrome and control of mumps. *MMWR* 1998; 47 (RR-8).
6. CDC. Prevention of varicella: Recommendations of the Advisory Committee on Immunization Practices. *MMWR* 2007; 56 (RR-4).
7. Tomblyn M, Einsele H, et al. Guidelines for preventing infectious complications among hematopoietic stem cell transplant recipients: a global perspective. *Biol Blood Marrow Transplant* 15:1143–1238; 2009 at [www.cdc.gov/vaccines/pubs/hemato-cell-transplants.htm](http://www.cdc.gov/vaccines/pubs/hemato-cell-transplants.htm).
8. CDC. Notice to readers: Revised ACIP recommendation for avoiding pregnancy after receiving a rubella-containing vaccine. *MMWR* 2001; 50 (49).
9. CDC. Updated recommendations for use of tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine (Tdap) in pregnant women: Recommendations of the ACIP. *MMWR* 2012; 62 (7):131–4.