

Immunization Screening Questionnaire

To ensure safe vaccinations, please read the following questions carefully and mark Patient/Parent or Legal Guardian as appropriate.

Name		Resident Registration Numbers	-	(<input type="checkbox"/> Male <input type="checkbox"/> Female)
Date of Birth (YYYY.MM.DD)		Foreign Registration Number	-	(<input type="checkbox"/> Male <input type="checkbox"/> Female)
Telephone	(Home)	(Cell Phone)	Weight	kg

Release of Personal Vaccination Information	Patient/ Parent or Legal Guardian <input checked="" type="checkbox"/>
<p>We collect personal information including Foreign Registration Number and Sensitive Information in accordance with the "INFECTIOUS DISEASE CONTROL AND PREVENTION ACT" Article 24, 32 and the "ENFORCEMENT DECREE OF THE INFECTIOUS DISEASE CONTROL AND PREVENTION ACT" Article 32-3. The additional personal information to be collected is as follows:</p> <p><input type="checkbox"/> Personal information collection-processing purpose: sending reminder messages regarding upcoming vaccination dates, confirmation messages for received vaccinations, and messages regarding the monitoring of adverse events following immunization.</p> <p><input type="checkbox"/> Personal information collection-processing category: personal information(including Foreign Registration Number and Sensitive Information), telephone(home, cell phone)</p> <p><input type="checkbox"/> Period of retention and use: 5 years</p>	
I hereby consent to the release of my child's (my) vaccination records through the Immunization Registry Information System (IRIS). * Denying consent could lead to unnecessary vaccinations or cross vaccinations.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I hereby consent to receiving reminder messages for upcoming vaccinations and confirmation of received vaccinations. * Denying consent will result in no longer receiving information on upcoming or received vaccinations.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I hereby consent to receiving messages for the monitoring of adverse events following immunization. * Denying consent will result in no longer receiving information on adverse events following immunization.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pre-Immunization Screening Checklist	Patient/ Parent or Legal Guardian <input checked="" type="checkbox"/>
Are you feeling sick today? If yes, please describe any symptoms. ()	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever experienced an allergic reaction such as urticaria or rash to certain medications, foods (especially eggs), or vaccinations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever experienced any adverse events following vaccination in the past? If yes, please specify the vaccine. ()	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been diagnosed with or treated for congenital anomaly, asthma, lung, heart, kidney, or liver problems, metabolic diseases (e.g. diabetes), or blood disorders? If yes, please specify.()	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you experienced seizures or other nervous system disorders (e.g. Guillain-Barre syndrome)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have cancer, hematologic diseases, or any other immune system problem? If yes, please describe. ()	<input type="checkbox"/> Yes <input type="checkbox"/> No
In the past three months, have you taken cortisone, prednisone, other steroids or anti-cancer drugs, or had radiation treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
In the past year, have you ever received a blood transfusion or immunoglobulin?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you received any vaccinations within the past month? If yes, please specify. ()	<input type="checkbox"/> Yes <input type="checkbox"/> No
(For women) Are you pregnant or is there a chance of becoming pregnant within the next month?	<input type="checkbox"/> Yes <input type="checkbox"/> No
I hereby confirm that I have been informed of my examination results and of the potential adverse events following immunizations (AEFIs), and hereby agree to receiving vaccination(s). Patient or Parent/Legal Guardian: _____ (Name) _____ (Signature) _____ (Relationship to patient) * National Registration Number of legal guardian (if your child's birth has not yet been registered): _____ - Date: (yyyy) (mm) (dd)	

Results of Pre-Vaccination Screening (to be completed by a physician)	Check <input checked="" type="checkbox"/>
Body temperature : _____ °C	<input type="checkbox"/>
I have explained about possible risks of immunization (AEFI)	<input type="checkbox"/>
I have explained that the vaccine recipient should stay at the medical institution for 20~30 minutes for observation.	<input type="checkbox"/>
Results of history-taking :	
Based on the patient's history and physical examination, the vaccine recipient is able to receive vaccinations. Physician (Name): _____ (Signature)	