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	-	(☐Male ☐Female)
Date of Birth (YYYY.MM.DD)		Foreign Registration Number	-	(☐Male ☐Female)
Telephone	(Home) (Cell Phone)		Weight	kg

Release of Personal Vaccination Information	Patient/ Parent or Legal Guardian ☑
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: ☐ **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.** ☐ **Personal information collection·processing category: personal information(including Foreign Registration Number and Sensitive Information), telephone(home, cell phone)** ☐ **Period of retention and use: 5 years**	
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.	☐ Yes ☐ 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.	☐ Yes ☐ 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.	☐ Yes ☐ No
Pre-Immunization Screening Checklist	**Patient/ Parent or Legal Guardian ☑**
Are you feeling sick today? If yes, please describe any symptoms. ( )	☐ Yes ☐ No
Have you ever experienced an allergic reaction such as urticaria or rash to certain medications, foods (especially eggs), or vaccinations?	☐ Yes ☐ No
Have you ever experienced any adverse events following vaccination in the past? If yes, please specify the vaccine. ( )	☐ Yes ☐ 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.( )	☐ Yes ☐ No
Have you experienced seizures or other nervous system disorders (e.g. Guillain-Barre syndrome)?	☐ Yes ☐ No
Do you have cancer, hematologic diseases, or any other immune system problem? If yes, please describe. ( )	☐ Yes ☐ No
In the past three months, have you taken cortisone, prednisone, other steroids or anti-cancer drugs, or had radiation treatment?	☐ Yes ☐ No
In the past year, have you ever received a blood transfusion or immunoglobulin?	☐ Yes ☐ No
Have you received any vaccinations within the past month? If yes, please specify. ( )	☐ Yes ☐ No
(For women) Are you pregnant or is there a chance of becoming pregnant within the next month?	☐ Yes ☐ 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 ☑
Body temperature : ℃	I have explained about possible risks of immunization (AEFI)	☐
I have explained that the vaccine recipient should stay at the medical institution for 20~30 minutes for observation.		☐
Results of history-taking :		
Based on the patient's history and physical examination, the vaccine recipient is able to receive vaccinations. Physician (Name): (Signature)		