[영어]

Screening Questionnaire for Immunization

Foreign Registration Number	- (☐M ☐F)	Telephone	
Name		Weight	kg
Address			

Pre-Immunization Screening Checklist	Parent(Guardian)/ Vaccinee ☑
Are you sick today? If yes, please describe the symptoms. ( )	☐ Yes ☐ No
Have you ever had an allergic reaction such as urticaria or rash after taking medications or food(including eggs), or receiving a vaccination?	☐ Yes ☐ No
Have you ever had an adverse event to a vaccine in the past? If yes, please specify the vaccination. ( )	☐ Yes ☐ No
Have you ever had been diagnosed with or treated for congenital anomaly, asthma, health problem with lung, heart, kidney, liver or metabolic disease(e.g. diabetes) or a blood disorder? If yes, please specify the health problem. ( )	☐ Yes ☐ No
Have you had a seizure or a brain or other nervous system problem(including Guillain-barre syndrome)?	☐ Yes ☐ No
Do you have cancer, leukemia or any other immune system problem? If yes, please describe the symptoms. ( )	☐ Yes ☐ No
In the past 3 months, have you taken cortisone, prednisone, other steroids or anticancer drug, or had radiation treatments?	☐ Yes ☐ No
In the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin?	☐ Yes ☐ No
Have you received vaccinations in the past 1 month? If yes, please specify the vaccination. ( )	☐ Yes ☐ No
(For women) Are you pregnant or is there a chance you could become pregnant during the next month?	☐ Yes ☐ No

I hereby give the consent for you to receiving vaccination(s) after being informed about the results of examination of you and the potential adverse events following immunization(AEFI).

Name of Parent(Guardian)/Vaccinee: (Signature) Relationship to the vaccinee:

Year _____ Month _____ Day _____

※ I hereby give the consent on receiving message for this vaccination and reminder message for the date of next vaccination ☐ Yes (Cellphone number :)

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 a vaccinee should stay in the medical institution for 20~30 minutes for observation		☐
Results of history-taking :		
Based on the history and physical examination, the vaccinee is able to receive vaccination. Name of physician : (Signature)		

The above information and results of examination will be stored securely for five years, and will only be used for vaccine safety evaluation (Article 26 of Enforcement regulations of the Infectious Disease Control and Prevention Act).

The immunization record is collected and shared among immunization providers for the purpose of preventing missed or duplicate vaccinations and issuing vaccination certificates (Article 28 of the Infectious Disease Control and Prevention Act and Article 23 of Enforcement regulations of the same above-mentioned Act). The record will be stored semi-permanently on the basis of Enforcement ordinance of Public Records Management Act.

The information shared include: personal information of the vaccinee (name, citizen registration number, address, telephone number); personal information of the parent or guardian; and the specifics of the vaccination received (vaccination name, dose of the series, date, type, method and site). This information is strictly secured and managed under the authority of the Act on the Protection of Personal Information (Act No. 10465).