

Immunization Screening Questionnaire

To ensure a safe vaccination, please read the following questions carefully and complete the form by selecting the appropriate response as either the **Patient, Parent, or Legal Guardian**.

Personal Information of Vaccine Recipient			
Full Name		Resident Registration Number	- (<input type="checkbox"/> Male <input type="checkbox"/> Female)
Date of Birth (YYYY.MM.DD)		Foreign Registration Number (if applicable)	- (<input type="checkbox"/> Male <input type="checkbox"/> Female)
Contact Number (Home)	(Mobile)	Weight	kg
Consent for Collection and Use of Personal Information			Identity Verification <input checked="" type="checkbox"/>
<p>In accordance with Article 32 of the Infectious Disease Control and Prevention Act and Article 32-3 of its Enforcement Decree, we collect personal and sensitive information, including your Resident Registration Number. The details of the collection and use are as follows:</p> <p>① Purpose of Collection and Use: To provide notifications regarding upcoming vaccinations and completion status / To monitor adverse events following immunization (AEFI) through SMS and mobile applications</p> <p>② Collected Information: Personal data (including sensitive information and Resident Registration Number) / Home and mobile phone numbers</p> <p>③ Retention period: 5 years</p>			
I hereby consent to the verification of my (or my child's) vaccination records through the Immunization Registry Information System (IRIS) under Article 26-2 of the Infectious Disease Control and Prevention Act. * If you do not consent, healthcare providers may request your vaccination history in writing, and you must comply unless there are special circumstances.			<input type="checkbox"/> Yes <input type="checkbox"/> No
I agree to receive SMS and mobile app notifications regarding upcoming vaccinations and completion status. * If you do not consent, you will not receive updates on vaccination schedule updates.			<input type="checkbox"/> Yes <input type="checkbox"/> No
I agree to receive SMS and mobile app notifications regarding the monitoring of adverse events following immunization (AEFI). * If you do not consent, you will not receive notifications related to AEFI monitoring.			<input type="checkbox"/> Yes <input type="checkbox"/> No
Pre-Immunization Screening Checklist (To be completed by the Patient, Parent, or Legal Guardian)			Identity Verification <input checked="" type="checkbox"/>
1. Have you received any vaccinations in the past month? If yes, please specify the vaccine. (_____)			<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever experienced adverse reactions following a vaccination that required medical treatment? If yes, please specify the vaccine. (_____)			<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are you feeling unwell today? If yes, please describe your symptoms. (_____)			<input type="checkbox"/> Yes <input type="checkbox"/> No
4. (For female recipients only) Are you currently pregnant or planning to become pregnant within the next month?			<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you ever had an allergic reaction (such as hives, rash, anaphylactic shock, breathing difficulties, loss of consciousness, or swelling of the lips/month) to medications, food (e.g., eggs), or vaccines?			<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you ever been diagnosed with cancer, leukemia, or an immune system disorder? If yes, please specify. (_____)			<input type="checkbox"/> Yes <input type="checkbox"/> No
7. In the past three months, have you received steroids, chemotherapy, or radiation therapy?			<input type="checkbox"/> Yes <input type="checkbox"/> No
8. In the past year, have you received a blood transfusion or immunoglobulin treatment?			<input type="checkbox"/> Yes <input type="checkbox"/> No
9. (For COVID-19 vaccination) Do you have a blood clotting disorder or are you currently taking anticoagulants? If yes, please specify the condition or medication. (_____)			<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Have you ever experienced seizures or neurological conditions (e.g., Guillain-Barré Syndrome)?			<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Have you ever been diagnosed with or treated for any congenital anomalies, asthma, lung disease, cardiovascular disease, kidney disease, liver disease, endocrine disorders (e.g., diabetes), or blood disorders (excluding blood clotting disorders)? If yes, please specify. (_____)			<input type="checkbox"/> Yes <input type="checkbox"/> No
Acknowledgement & Consent for Vaccination			
I confirm that I have received an explanation regarding my (or my child's) medical examination and potential adverse events following immunization (AEFI). I consent to the administration of the vaccination.			
Patient, Parent, or Legal Guardian Name: _____			(Signature)
Relationship to Vaccine recipient: _____			
* National Registration Number of Legal Guardian (if your child's birth has not yet been registered): _____			Date(yyyy/mm/dd): _____
Physician's Pre-Vaccination Screening Results (To be completed by the physician)			Check <input checked="" type="checkbox"/>
Body Temperature: _____ °C	The recipient has been informed of potential adverse reactions following immunization (AEFI).		<input type="checkbox"/>
The recipient has been advised to remain at the medical institution for 20-30 minutes for post-vaccination observation.			<input type="checkbox"/>
Results of history-taking:			
Based on the patient's history and physical examination, the recipient is cleared for vaccination.			
Physician's Name: _____			(Signature)