Patient name:_____ Date of birth:____/_____/___AGE_____

Screening Questionnaire for Child and Teen Immunization

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. Is the child sick today?	☐	☐	☐
2. Does the child have allergies to medications, food, or any vaccine?	☐	☐	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Has the child had a health problem with asthma, lung disease, heart disease, kidney disease, metabolic disease (e.g., diabetes), or a blood disorder?	☐	☐	☐
5. If the child to be vaccinated is between the ages of 2 and 4 years, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐	☐	☐
6. Has the child had a seizure, brain, or other nervous system problem?	☐	☐	☐
7. Does the child have cancer, leukemia, AIDS, or any other immune system problem?	☐	☐	☐
8. Has the child taken cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments in the past 3 months?	☐	☐	☐
9. Has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug in the past year?0	☐	☐	☐
10.Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐	☐
11. Has the child received vaccinations in the past 4 weeks?	☐	☐	☐

12. Please circle the correct response about insurance — medical card / no insurance / private insurance

13. If you have private insurance, does it have full coverage or limited coverage for vaccines? full limited

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 record card, ask your healthcare provider to give you one! Bring this record with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

I have read or have had explained to me the information in the Vaccine Information Statements. I understand what I have read and all my questions have been answered to my satisfaction. I believe I understand the benefits and risks of the vaccine (s) and I ask that the vaccine(s) be given to me.
I hereby acknowledge receipt of the Preble County General Health District's NOTICE OF PRIVACY PRACTICES.
I grant permission for this record to be released to medical providers, public health departments, schools/daycare facilities and to the Ohio Department of Health's Impact SIIS Immunization Registry to transmit the immunization history.

www.immunize.org/catg.d/p4065scr.pdf . Item#P4065 (7/06)

Form completed by: X_____ Date:_____