Screening Questionnaire for Today's Immunizations

For parents and guardians: This form helps us decide which vaccines should be given in clinic today. Please answer these questions by checking the boxes. If the question is not clear, please ask the nurse or the doctor to explain it. Explain any "yes" answers in the space below the question.

	Yes	No	Don't Know
1. Has the child been sick or had fever in the last 3 days? _____	ÿ	ÿ	ÿ
2. Does the child have any chronic health problems? _____	ÿ	ÿ	ÿ
3. Does the child have allergies to medications, eggs, or any previous vaccines?_____	ÿ	ÿ	ÿ
4. Has the child had a serious reaction to vaccines in the past? _____	ÿ	ÿ	ÿ
5. Has the child ever had a seizure for any reason? _____	ÿ	ÿ	ÿ
6. Does the child have cancer, an immune system disorder, or does the child take medications that suppress the immune system such as steroids(by mouth or injection) or anti-cancer drugs? _____	ÿ	ÿ	ÿ
7. Does someone with whom the child lives (or has close contact) have cancer, any immune system disorder, HIV/AIDS or, take medications that suppress the immune system such as steroids (by mouth or injection) or anti-cancer drugs?_____	ÿ	ÿ	ÿ
8. Has the child received blood, plasma, or glammaglobin in the past 12 months? _____	ÿ	ÿ	ÿ
9. Is there any possibility the patient is pregnant or at risk of becoming pregnant within the next 3 months? _____	ÿ	ÿ	ÿ
10. Is the child on any type of medication? If yes, what is the medication? _____	ÿ	ÿ	ÿ
11. Has the child had chickenpox? If yes, how old was the child?_____	ÿ	ÿ	ÿ

***Patient/Parent Signature*_____ *Date*_____**