SCREENING QUESTIONNAIRE FOR CHILD AND TEEN IMMUNIZATION

For Parents/Guardians: The following questions will help us determine which vaccines may be given today. If a question is not clear, please ask the nurse to explain it.

	Yes	No
1. Is this child sick today		
2. Does this child have allergies to medications, food (eggs, gelatin), latex, or any vaccine component? **Please explain:** _____		
3. Has this child had a serious reaction to a vaccine in the past?		
4. If your child is a baby, have you ever been told he/she has had intussusception?		
5. Has this child, a sibling, or a parent had a seizure or has the child had brain or other nervous system problems?		
6. Does this child have cancer, leukemia, HIV/AIDS, or any other immune system problems?		
7. In the past 3 months, has this child taken cortisone, prednisone, other steroids, anticancer drugs, or had radiation treatments?		
8 In the past year, has this child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral medication?		
9. Is the teen pregnant or is there a chance she could become pregnant during the next month?		
10. Has this child received any vaccinations in the past 4 weeks?		
11. Has the person to be vaccinated ever had Guillain-Barré syndrome?		
To Receive FluMist answer the following questions also.		
12. Is the person to be vaccinated younger than age 2 years or older than age 49 years?		
13. Does the person to be vaccinated have a long-term health problem with heart, lung (including asthma), kidney or, neurologic disease, liver disease, disease (e.g. diabetes), or anemia or another blood disorder?		
14. If the person to be vaccinated is a child age 2 through 4 years, in the past 12 months, has a healthcare provider told you the child had wheezing or asthma?		
15. Is the child or teen (2-17 years) to be vaccinated receiving aspirin therapy or aspirin-containing therapy?		
16. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., and isolation room of a bone marrow transplant unit)?		

Child's Legal First and Last Name:	Date of Birth:	Gender	CAIR #	Post Card
1.		M F		
2.		M F		
3.		M F		
4.		M F		

Mother's Name:	Does your child have any of the following health coverage? **Check one box below:**
Mailing Address:	Medi-Cal /CHDP
City:	**NO** insurance
Zip Code:	American Indian /Alaskan Native?
Phone Number:	Private Insurance

Parent/Guardian Signature: _____ **Today's Date:** _____

For staff use only: Next to each vaccine received please add injection site

Administered by:

_____ _____ _____ _____

Name: **CAIR #** **☐ VFC ☐ State**	**Name:** **CAIR #** **☐ VFC ☐ State**	**Name:** **CAIR #** **☐ VFC ☐ State**	**Name:** **CAIR #** **☐ VFC ☐ State**
DTaP	DTaP	DTaP	DTaP
IPV	IPV	IPV	IPV
Hib	Hib	Hib	Hib
Hep. B	Hep. B	Hep. B	Hep. B
PNUcon. (PCV13)	PNUcon. (PCV13)	PNUcon. (PCV13)	PNUcon. (PCV13)
Rota	Rota	Rota	Rota
Pediarix	Pediarix	Pediarix	Pediarix
Kinrix	Kinrix	Kinrix	Kinrix
Pentacel	Pentacel	Pentacel	Pentacel
MMRV	MMRV	MMRV	MMRV
VZV	VZV	VZV	VZV
MMR	MMR	MMR	MMR
Hep. A	Hep. A	Hep. A	Hep. A
Meningo (MCV4)	Meningo (MCV4)	Meningo (MCV4)	Meningo (MCV4)
Tdap Booster	Tdap Booster	Tdap Booster	Tdap Booster
HPV	HPV	HPV	HPV
Td Booster	Td Booster	Td Booster	Td Booster
Flu IIV LAIV	Flu IIV LAIV	Flu IIV LAIV	Flu IIV LAIV

NOTICE OF PRIVACY_____ IZ REGISTRY CONSENT _____ VACCINE INFORMATION SHEET GIVEN _____

Pediarix = DTaP / IPV / HB
Kinrix = DTaP / IPV
Pentacel = DTaP / HIB / IPV