

Screening for Immunization

Patient: _____

Date: _____

	Yes	No	Don't Know
1. Is the child sick today?			
2. Does the child have allergies to medications, food, a vaccine component, or latex?			
3. Has the child had a serious reaction to a vaccine in the past?			
4. Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g. diabetes), asthma, or a blood disorder and if so, on a long-term aspirin therapy?			
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 has had wheezing or asthma in the past 12 months?			
6. If your child is a baby, have you ever been told he or she has had intussusception?			
7. Has the child, a sibling, or a parent had a seizure? Or has the child had brain or other nervous system problems?			
8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?			
9. In the past 3 months, has the child taken medications that weaken their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?			
10. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?			
11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?			
12. Has the child received vaccinations in the past 4 weeks?			
Did you bring your immunization record card with you?			