Screening Questionnaire for Child and Teen Immunization

Patient Name:_____Date of Birth: __/__/_____ Age:____ Sex:____

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, a vaccine component or latex?	☐	☐	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Does the child have a health problem with asthma, lung disease, heart disease, kidney disease, metabolic disease (e.g. diabetes) or a blood disorder? Is your child on aspirin therapy?	☐	☐	☐
5. For children aged 2 through 4 years: Has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐	☐	☐
6. For babies: Have you ever been told the child had intussusception?	☐	☐	☐
7. Has the child, a sibling, or parent had a seizure, brain disorder or other nervous system problems?	☐	☐	☐
8. Has the child ever been diagnosed with a heart condition (myocarditis or pericarditis) or had Multisystem Inflammatory Syndrome (MIS-C) after an infection with the virus that causes COVID-19?	☐	☐	☐
9. Does the child have an immune-system problem such as cancer, leukemia, HIV/AIDS?	☐	☐	☐
10. In the past 6 months, has the child taken medication that affect the immune system such as prednisone, other steroids, or anti-cancer drugs; drugs to treat rheumatoid arthritis, Crohn's disease or Psoriasis; or had radiation treatments?	☐	☐	☐
11. Does the child's parent or sibling have an immune system problem?	☐	☐	☐
12. In the past year has the child received immune (gamma) globulin, blood/blood products, or an antiviral drug?	☐	☐	☐
13. Is the child/teen pregnant?	☐	☐	☐
14. Has the child received vaccinations in the past 4 weeks?	☐	☐	☐
15. Has the child ever felt dizzy or faint before, during or after a shot?	☐	☐	☐
16. Would you like to receive email or text reminders for immunizations? (If yes, circle preferred method.)	**Yes**	**No**	

Please be aware that if you cannot safely restrain your child/teen, or they refuse to be vaccinated, you and your child/teen will be asked to reschedule for a future date.

I was given an explanation about the diseases and vaccines. I had the opportunity to ask questions that were answered to my satisfaction and/or received a Vaccine Information Sheet. I understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) be given to me or the person named above for whom I am authorized to make this request. I hereby consent that the Local Health Department (LHD), or designee, from whom I received the vaccination can bill my insurance, if applicable. I understand I am financially responsible for any fees not covered by my insurance company. I authorize the release of this record to the Ohio Department of Health Immunization Program. I hereby acknowledge receipt of the LHD Notice of Health Information Privacy Practice and give permission to release my child's immunization record to their doctor, school or other agency as needed by email, mail or fax. If indicated on this form, I authorize the LHD or designee to charge my account. For clients ages 17 and under, parent/guardian must give consent to allow client to receive vaccines without parent/guardian present.

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Form Completed By: _____Date:_____