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 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 your child is a baby, have you ever been told he or she has had intussusception?	☐	☐	☐
6. 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?	☐	☐	☐
7. Has the child had a seizure, brain disorder or other nervous system problems?	☐	☐	☐
8. Does the child have cancer, leukemia, AIDS, or any other immune system problem?	☐	☐	☐
9. Has the child taken cortisone, prednisone, other steroids, anti-cancer drugs or had radiation treatments in the past 3 months?	☐	☐	☐
10. Has the child received a blood transfusion or blood products or been given immune (gamma) globulin or an antiviral drug in the past year?	☐	☐	☐
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?	☐	☐	☐
13. Please circle the correct response about insurance.	Medicaid Card	No Insurance	Private Insurance
14. If you have private insurance, does it have limited or full coverage for vaccines?	full coverage	limited coverage	don't know
15. Is your child on WIC?		Yes	No
16. Would you like to receive email or text reminders for immunizations? (If yes, circle preferred method.)		Yes	No

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 immunization record to my doctor or agency/school. If indicated on this form, I authorize the LHD or designee to charge my account. For clients age 17 and under, parent and/or guardian consents to allow client to receive vaccine without parent and/or guardian present.

Form Completed By: _____Date:_____