Public Health
MADISON & DANE COUNTY
Healthy people and places

Screening Questionnaire for Child and Teen Immunization

Patient name: _____ Date of birth: _____

For parents: These questions will help us decide which vaccines your child needs today. If you answer "yes" to any question it does not mean your child will not be vaccinated. The nurse may need to ask more questions.	**Yes**	**No**	**Don't Know**
Are you the parent of this child?	☐	☐	
1. Is the child sick today?	☐	☐	☐
2. Does the child have allergies to medications, food, latex or any vaccines? List: _____	☐	☐	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Does the child have lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Is he/she on long-term aspirin therapy? Circle	☐	☐	☐
5. If this child is between 2 and 4 years old: In the past year, has a health care provider told you that the child had wheezing or asthma?	☐	☐	☐
6. If your child is a baby, have you ever been told he or she has had intussusceptions?	☐	☐	☐
7. Has the child, sibling, or parent ever had a seizure, paralysis, or a problem with the brain or nervous system? Circle	☐	☐	☐
8. Does the child or a family member have cancer, leukemia, HIV/AIDS, or any other immune system problems? Circle	☐	☐	☐
9. In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	☐	☐	☐
10. In the past year has the child received a blood transfusion, blood products or been given a medicine called immune (gamma) globulin or an antiviral drug? Circle	☐	☐	☐
11. For girls: Is she pregnant or planning a pregnancy in the next month? If pregnant, how many weeks? _____	☐	☐	☐
12. Has the child received any vaccinations in the past 4 weeks?	☐	☐	☐
13. Has the child ever had chickenpox disease? Estimated year: _____	☐	☐	☐
14. Child's current weight: _____			
15. Does the child need a TB (tuberculosis) test in the next 4 weeks?	☐	☐	☐

Adapted from the Immunization Action Coalition

We ask you wait in the clinic for 15 minutes after the shots.

Signature of person completing the form: _____ Date: _____

Nurse's signature: _____ Date: _____

Interpreter use: Pacific Interpreters (phone): ☐ Yes ☐ No
In-Person (name): _____ Declined: ☐ Yes ☐ No