Patient ID________________ Temp______C

Pre-vaccination Screening Questionnaire for Child / Teen

The following questions will help us determine if we can safely vaccinate your child today.

Please ask the doctor to explain anything that is not clear to you or your child, prior to the vaccination.

Patient Name		Date of Birth	/ / (Mo. / Day / Yr)

	Yes	No	Don't know
1. Is your child sick today?			
2. Does your child have any allergies to medications, food or vaccines?			
3. Has your child had a severe reaction to any vaccine in the past?			
4. Has you child had any lung disease (including asthma), heart disease, kidney disease, blood disease, or diabetes?			
5. Has you child ever had a seizure, brain or other neurologic problem?			
6. Does you child have cancer, leukemia, AIDS, or any other serious immune system problem?			
7. Has your child taken cortisone, prednisone, or any other steroid medications in the past three months?			
8. Has your child had chemotherapy or radiation therapy in the past three months?			
9. Has your child received blood transfusions or other blood products or immunoglobulin in the past one year?			
10. Is your child pregnant?			
11. Has your child received any other vaccinations in the past 4 weeks?			

I have read the information provided regarding the vaccine(s) and understand the risks and benefits of the vaccinations planned for administration. My questions have been answered and I agree to the administration of the vaccine(s) to the above named person.

____ ______________________

Signature of Parent or Guardian Date

[Relationship:________________________________]