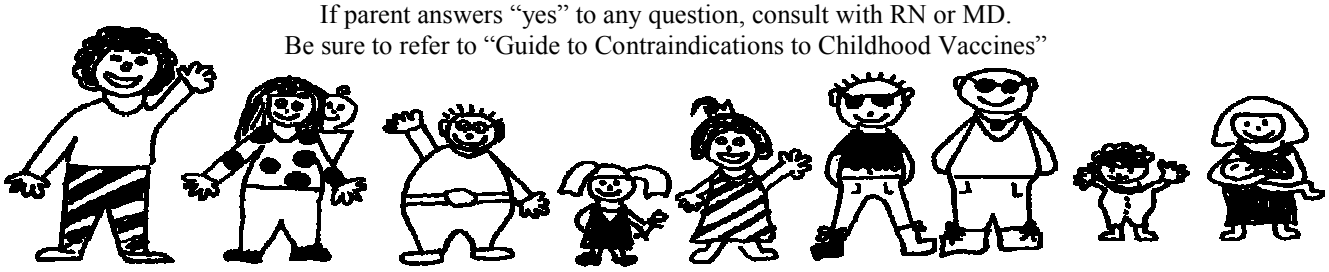
BASIC SCREENING QUESTIONS

PLEASE ANSWER THE FOLLOWING QUESTIONS BY MARKING A CHECK IN THE APPROPRIATE BOX SIGN NAME AND DATE BELOW.

If parent answers "no" to all these questions, immunize the child.
If parent answers "yes" to any question, consult with RN or MD.
Be sure to refer to "Guide to Contraindications to Childhood Vaccines"



Child's Name_____

Date of Birth_____/_____/_____

	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
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 seizure or a brain problem?										
5. Does the child have cancer, leukemia, AIDS, or any other immune system problem?										
6. Has the child taken cortisone, prednisone, other steroids, or anticancer drugs, or had x-ray treatments in the past 3 months?										
7. Has the child received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year?										
8. Is the child/teen pregnant or is there a chance she could become pregnant in the next 3 month? Date of LMP:_____										
9. Has the child received any vaccinations in the past 4 weeks?										
10. <u>For Infants Only:</u> Is the mother of the infant chronically infected with hepatitis B? (A hepatitis B carrier?)										
	1		2		3		4		5	

<u>Parent/Guardian Signature</u> <u>Date</u>

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____