

DEWITT PIATT BI-COUNTY HEALTH DEPARTMENT

910 Route 54 East P.O. Box 518 Clinton, IL

IMMUNIZATION CLINIC

SCREENING QUESTIONNAIRE

Name of client to be vaccinated:

If the answer is "YES" to any question, please give explanation below question.

1. Is the client sick today with an illness other than a cold; or had a fever of 100 degrees or greater during the last 24 hours?

YES	NO
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2. Does the client have **any** allergies?

YES	NO
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Is the client allergic to latex, eggs, gelatin, medications, or any vaccines?

YES	NO
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List allergies:

3. Has the client ever had a serious reaction after receiving an immunization?

YES	NO
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4. Has the client ever had a seizure, brain or nerve problem?

YES	NO
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5. Does the client have cancer, leukemia, A IDS or any other immune system problem?

YES	NO
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6. Does the client take Cortisone, Prednisone, other steroids, anticancer drugs, or have x-ray treatments?

YES	NO
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7. Has the client received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year?

YES	NO
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8. Is the client pregnant or could become pregnant in the next month?

YES	NO
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9. Has the client received immunizations in the past 4 weeks?

YES	NO
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10. Has the client had a health problem with asthma lung disease, heart disease, kidney disease, metabolic disease (e.g. diabetes), or a blood disorder?

YES	NO
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11. If the client to be vaccinated is 2 to 4 years of age, has a healthcare provider told you the child had wheezing or asthma in the past 12 months?

YES	NO
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Signature of Parent/Client/Legal Guardian/Grandparent
(Please circle the appropriate relationship to client)

Date

Emergency Contact &
phone number

Turn page over and complete the top section only --plus signature!