

DEWITT PIATT BI-COUNTY HEALTH DEPARTMENT

1020 S MARKET, MONTICELLO IL 61856

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

2. Does the client have any allergies? YES NO
Is the client allergic to latex, eggs, gelatin, medications, or any vaccines? YES NO

List allergies:

3. Has the client ever had a serious reaction after receiving an immunization? YES NO

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

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

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

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

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

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

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

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

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!