IMMUNIZATION SCREENING FORM

Note: The questions apply to the person receiving vaccines today. If a question is not clear, please ask clinic staff to explain it. PLEASE PRINT!

Name: _____ Birthdate: _____
(Last) (First) (MI)

		YES	NO	DON'T KNOW
1.	Are you sick today?	☐	☐	☐
2.	Do you have allergies to medications, to any vaccine, latex, yeast, eggs, gelatin, alum, or any preservatives?	☐	☐	☐
3.	Have you ever had a serious reaction to a vaccine in the past?	☐	☐	☐
4.	Have you ever had a seizure or a history of Guillain-Barré syndrome (GBS)?	☐	☐	☐
5.	Do you, any person who lives with you, (or who has close contact with you), have cancer, leukemia, AIDS, or any other immune system problem?	☐	☐	☐
6.	Have you, or any person who lives with you received cortisone, prednisone, other steroids, anticancer drugs, or x-ray treatments in the past 3 months?	☐	☐	☐
7.	During the past year, have you received a transfusion of blood or plasma, or been given a medicine called immune globulin?	☐	☐	☐
8.	Do you have a long-term health problem such as asthma or other lung disease, heart disease, kidney disease, diabetes, anemia, or other blood disorder?	☐	☐	☐
9.	Have you received any vaccinations in the past 4 weeks?	☐	☐	☐
10.	Have you had chickenpox disease? If yes, when? _____	☐	☐	☐
11.	**For infants 8 weeks to 32 weeks:** Was your child born prematurely?	☐	☐	☐
12.	**For children over 2 years of age:** Has a healthcare provider told you that your child had wheezing or asthma in the past 12 months?	☐	☐	☐
13.	**For children 5 years old:** Does your child suffer from any chronic medical conditions?	☐	☐	☐
14.	**For females age 12 years or older:** Is it possible that you are pregnant or may become pregnant in the next 3 months?	☐	☐	☐

Bring your immunization record every time you come to Public Health or go to the doctor!
Talk to your doctor for suggested frequency of recommended well physical exams.

ADULTS NEED SHOTS TOO! Have you had a tetanus booster in the last 10 years?

I understand Sheboygan County Health and Human Services may bill Forward Health, Medicare or any other 3rd party insurance company for billable services. I have read and completed this screening form to the best of my knowledge and request that the above named person be immunized.

_____ _____
Date Signature (Parent or Legal Guardian's Signature required for persons under 18 years)

_____
Public Health Nurse Reviewing History