

Office Use Only:

Screened By: _____

Return Date: _____

Tdap # _____ Meningococcal # _____

Hep A # _____ HPV# _____

IZ Registry # _____

Shots given by: _____ Date: _____

Children's Immunization Questionnaire

Please complete a questionnaire for Child receiving immunizations today.

Child's Name: _____
Last First MI Date of Birth Age

Language: _____ Ethnic Group: _____ Gender: _____

Please answer the following questions for the child receiving immunizations today:

1. Has your child had a serious reaction to a vaccine in the past? Yes No
2. Is your child sick today? Yes No
3. Has your child taken cortisone, prednisone, other steroids, anticancer drugs, or had x-ray treatments in the past 3 months? Yes No
4. Does your child have cancer, leukemia, AIDS or any other immune system problem? Yes No
5. Has your child had a seizure, brain, or nerve problem? Yes No
6. Does your child have allergies to medications, food, or any vaccine? Yes No
7. Has your child 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 your child currently taking aspirin? (Except in rare cases, children should not be given aspirin, especially after Varicella vaccine.) Yes No
9. Has your child had the chickenpox? Yes No
10. Is the child/teen pregnant or is there a chance she could become pregnant during the next month? Yes No
11. Has your child received vaccinations in the past 4 weeks? Yes No