# 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