MASON COUNTY HEALTH DEPARTMENT
IMMUNIZATION SCREENING QUESTIONNAIRE

This form helps us decide which vaccines should be given in the clinic today. Please answer these questions by circling the answer. If the question is not clear, please ask the nurse to explain it.

Client's Name:_____**Birthdate:mo____day____year_____**

Your Doctor's Name:_____

1. Is the client sick today? Or has the client had a fever of 100 degrees or greater during the last 24 hours?	Yes No
2. Has the client received an immunization within the last 4 weeks?	Yes No
3. Does the client or any person who lives with or takes care of the client have cancer, AIDS, or any other immune system problem? Or have they taken cortisone, prednisone, other steroids, anti-cancer drugs, or x-ray treatments in the last 3 months?	Yes No
4. Is the client allergic (swelling of mouth or throat, difficulty breathing, shock) to medications, food, or any vaccine?	Yes No
5. Has the client had a blood or plasma transfusion or received immune globulin within the past year?	Yes No
6. Has the client ever had convulsions or other neurological problems?	Yes No
7. Is the client pregnant or planning to become pregnant in the next month?	Yes No
8. Has the client ever had a serious reaction to a previous immunization such as fever greater than 104 degrees, convulsions, total collapse or shock, high-pitched cry or screaming episode of 3 hrs. or more, severe itching rash or anaphylactic reaction?	Yes No
9. Is the person receiving the vaccine(s) a foster child?	Yes No
10. Do you object to the release of immunization records held by the Mason County Health Department to medical providers, daycare providers, and school authorities?	Yes No
11. What is the client's weight?	_____

If the answer to any of the above questions is "yes", consult with the nurse before immunizations are given.

Parent/Legal Guardian Signature_____**Date**_____

Nurse or Person Reviewing Form_____**Date**_____

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