



Patient Name: _____ Date of Birth: _____

CLINIC SCREENING FOR INFANTS, CHILDREN & TEENS

For the parent/guardian: Answering the following questions will help us better care for your child today. If a question is not clear, please ask the nurse to explain it.

- | | Yes | No | Don't Know |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|
| 1. Is the child sick today? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does the child have allergies to medications, food, or any vaccine? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has the child had a serious reaction to a vaccine in the past? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has the child had a health problem with asthma, lung disease, heart disease, kidney disease, metabolic disease (ie; diabetes), or a blood disorder? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. If the child to be vaccinated is between 2 and 4 years, has a healthcare provider told you that the child had wheezing or asthma in the last 12 months? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Has the child had a seizure, brain, or other nervous system problem? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Has the child taken cortisone, prednisone, other steroids, or anticancer drugs, or had x-ray treatments in the past 3 months? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Has the child received a transfusion of blood products, or been given a medicine called immune (gamma) globulin in the past year? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Is the child/teen pregnant or is there a chance she could become pregnant during the next month? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has the child received vaccinations in the past 4 weeks? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Did you bring your child's immunization record with you? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Is your child American Indian or Alaskan Native? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Is your child covered by: <input type="checkbox"/> Medicaid, <input type="checkbox"/> Private Insurance <input type="checkbox"/> No Insurance | | | |
| 15. If private insurance is marked above, do you have coverage for immunizations (regardless of deductibles)? <input type="checkbox"/> yes <input type="checkbox"/> no | | | |

Form completed by: _____ Relationship _____ Date: _____

Form reviewed by: _____ Date: _____