SCREENING QUESTIONS FOR PERSONS TO BE IMMUNIZED.

Have you received any vaccines anywhere other than this clinic? □ YES □ NO
Did you bring an immunization record with you today? □ YES □ NO

Please answer the following questions about the person receiving vaccines today.

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does the person receiving vaccines today have a fever?</td>
<td></td>
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<tr>
<td>2. Has cancer, lymphoma, HIV/AIDS or any other immune system problem?</td>
<td></td>
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<tr>
<td>3. Takes medication, treatment, or radiation for above diseases?</td>
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<tr>
<td>4. Takes any cortisone-like medication?</td>
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<tr>
<td>5. Received any vaccinations in the past 4 weeks?</td>
<td></td>
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<tr>
<td>6. Had a serious reaction after receiving a vaccination?</td>
<td></td>
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<tr>
<td>7. Is allergic to Neomycin, Streptomycin, Polymixin B, Thimerosal, gelatin or yeast?</td>
<td></td>
</tr>
<tr>
<td>8. Is pregnant or plans to become pregnant within the next 1 month?</td>
<td></td>
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<tr>
<td>9. Has had a seizure or other nervous system problem or a family history of seizures?</td>
<td></td>
</tr>
</tbody>
</table>

Hepatitis B (HBV)
1. Currently has Hepatitis B or is a Hepatitis B carrier?

MMR, Varicella, or ProQuad
1. Has received a gamma globulin, blood transfusion, plasma, or blood platelets within the last 11 months?
2. Has had the Chicken Pox disease? If yes, Month ____ Year ____

RotaTeq
1. Have you ever been told your baby has had intussusception?

Influenza vaccine
1. Are you allergic to eggs, egg products, or have serious reactions if eggs are eaten?
2. Have you ever had Guillain-Barre Syndrome?

Pneumonia
1. Since age 65, have you received a pneumonia vaccination?
2. Have you ever received a pneumonia vaccination?

TB (Tuberculosis skin test)
1. Has had Tuberculosis or a positive tuberculosis test?
2. Has had a viral illness more serious than a cold within the past 60 days?

I have been given or read the vaccine information sheets □ (Please Check)  Refused VIS □ (Please Check)

___________________ X ____________________________
Date Signature of Person to Receive Immunization(s)/Vaccine(s)/TB skin test
Or person authorized to request services (parent/guardian if under 19 years of age)

___________________ ____________________________
Name of Interpreter (if needed) Signature of Interpreter (if needed)

Reference (if other than self)

Language Interpreted (if needed)

***NOTE: This statement expires 14 days after the date this form is signed. 05/2018