Lincoln-Lancaster County Health Department
3131 "O" STREET
LINCOLN, NE 68510-1514
402-441-8000

VFC: ☐ MC ☐ Arbor/non-billable ☐ Underinsured ☐ Uninsured
☐ Alaskan/Native American ☐ HS (VFC Guidelines)
NONVFC: ☐ Private Pay ☐ Refugee ☐ AGR37 ☐ HS (PP/AGR37)

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.

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

_____ _____ _____
Name of Interpreter (if needed) — Signature of Interpreter (if needed) — Language Interpreted (if needed)

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