

Cincinnati Health Department  
IMMUNIZATION SCREENING QUESTIONNAIRE

**Circle the answers to questions.** The following questions will help us determine which vaccines your child will be given. If you answer “yes” to any question, it does not necessarily mean your child should not be vaccinated. Additional information may be needed from you or the doctor.

**Child’s Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**Vaccines to be administered:** \_\_\_\_\_

1. Is your child sick today with something more serious than a cold? <i>(All Vaccines)</i>	YES	NO
2. Does your child have a serious allergy to latex, medications, food, eggs, thimerosal, or any vaccine? <i>(All vaccines)</i> If yes, what to? _____ Describe what happens _____	YES	NO
3. Has your child had a serious reaction to a vaccine in the past? <i>(All vaccines)</i> If yes, describe _____	YES	NO
4. Has your child had a seizure or a neurological problem or have a history of Guillain-Barre syndrome? <i>(All vaccines)</i>	YES	NO
5. In the past 3 months, has your child taken cortisone, prednisone, other steroids, anti-cancer drugs, or x-ray treatments? <i>(LAIV, MMR, Varicella)</i> If yes, describe _____	YES	NO
6. Does your child have cancer, leukemia, AIDS, or any other immune system problem? <i>(LAIV, MMR, RV, Varicella)</i> If yes, describe _____	YES	NO
7. In the past year, has your child received a transfusion of blood, plasma, a medicine called Immune globulin or an anti-viral drug? <i>( LAIV, MMR, Varicella)</i> If yes, what _____	YES	NO
8. If the child is between the age of 2 and 4 years, has a healthcare provider told you that your child had wheezing or asthma in the past 12 months? <i>(LAIV)</i>	YES	NO
9. If your child is a baby, have you ever been told he or she had intussusception? <i>(rotavirus)</i>	YES	NO
10. Does your child live with or have close contact with someone with a severely weakened immune system (i.e. an isolation room of bone marrow transplant unit)? <i>(LAIV)</i>	YES	NO
11. Has your child had a health problem with lung, kidney, or metabolic disease (ie, diabetes), asthma or a blood disorder? Is he or she a long term aspirin therapy? <i>(LAIV)</i>	YES	NO
12. Is the child/teen pregnant or is there a chance she could become pregnant in the next month? <i>(Leave blank if child is male.)</i> <i>(LAIV, MMR, Varicella)</i> If yes, what _____	YES	NO
13. Has your child received any vaccinations in the past 4 weeks? <i>(LAIV, MMR, Varicella)</i>	YES	NO

**Info provided by:** \_\_\_\_\_ **Relationship to child:** \_\_\_\_\_

**Verbal permission obtained from:** \_\_\_\_\_ **Relationship to child:** \_\_\_\_\_

**Form completed by:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Form reviewed by (RN):** \_\_\_\_\_ **Date:** \_\_\_\_\_

