WEST ALLIS HEALTH DEPARTMENT
SCREENING QUESTIONNAIRE FOR TODAY'S IMMUNIZATIONS

Public Health
Prevent. Promote. Protect.
West Allis Health Department

Name of Person Receiving Vaccine: _____ Date of Birth: mo____ day____ year____

If a minor, Parent(s) or Legal Guardian's Name(s): _____Today's Date: mo____ day____ year____

_____

Your answers to the questions below will assist us in determining what vaccines can be safely administered today. Please place a check mark by the appropriate boxes. If any of the questions are not clear, please ask the nurse for an explanation.

Does the person receiving the vaccine:	**Yes**	**No**	**Don't Know**
▪ Have a fever, diarrhea, or vomiting today?	❑	❑	❑
▪ Have allergies to eggs, Streptomycin, Neomycin, Gentamycin, gelatin, yeast, alum, Mercury products, latex, or any previous vaccines?	❑	❑	❑
▪ Have a history of a serious reaction to a vaccine in the past?	❑	❑	❑
▪ Have a seizure or a changing neurological disorder or a history of Guillain-Barre Syndrome?	❑	❑	❑
▪ Have cancer, an immune system disorder, or take medications that have weakened their immune system, such as steroids (by mouth or injection) or anti-cancer drugs?	❑	❑	❑
▪ Have a bleeding disorder like hemophilia or are they taking medication to thin their blood (anticoagulants)?	❑	❑	❑
▪ If age 6 months – 8 years, believe they have received a flu vaccine in the past?	❑	❑	❑
If receiving vaccines other than flu, continue answering the questions below:			
▪ Feel sick today with something more serious than a cold?	❑	❑	❑
▪ Have a history of receiving any vaccines in the last six weeks?	❑	❑	❑
▪ Live with (or has close contact with) someone who has cancer, an immune system disorder, or take medications that weaken the immune system such as steroids (by mouth or injection) or anti-cancer drugs?	❑	❑	❑
▪ Have a history of receiving blood, plasma, or Gamma Globulin in the past year?	❑	❑	❑
▪ Have a history of gastrointestinal disorders, including chronic diarrhea, failure to thrive, congenital abdominal disorders, abdominal surgery, or intussusception?	❑	❑	❑
▪ Remember receiving a skin test for tuberculosis in the last 1-3 days?	❑	❑	❑
▪ Plan to have a skin test or blood test for tuberculosis in the next four weeks?	❑	❑	❑
<u>For Girls/Women</u> – does the person receiving the vaccine: ▪ Believe she is pregnant or believe there is a chance she could become pregnant in the next 4 weeks?	❑	❑	❑

Adult/Parent/Legal Guardian Signature _____

❑ Yes ❑ No I give my permission for my child to be held during administration of the vaccines if necessary.

OFFICE USE ONLY

Nurse's Signature _____

❑ Interpreter services used – appropriate VIS given. Language:_____

❑ Fee $_____ for _____ ❑ Vaccine Fee Waived
Amount Vaccine ❑ WA City Employee, Fee Waived