Medical Screening Questionnaire and Consent for Vaccination

Please answer the following questions about you or the person to be vaccinated:

1. Have you received any vaccine within the past 30 days?	NO	YES
2. Are you or do you think you may be pregnant?	NO	YES
3. Have you ever had a serious reaction to a vaccine?	NO	YES
4. Are you allergic to latex, eggs, yeast, gelatin, thimerosal or any antibiotics (penicillin, sulfa, etc)?	NO	YES
5. Are you currently ill or running a fever?	NO	YES
6. Are you taking any medications?	NO	YES
7. Are you currently receiving aspirin therapy?	NO	YES
8. Do you have severe thrombocytopenia (low platelet count) or a bleeding disorder?	NO	YES
9. Have you received a blood transfusion, immune globulin or any other blood product within the last 12 months?	NO	YES
10. Have you ever had Guillian-Barre' Syndrome (GBS) or any other neurologic disease?	NO	YES
11. Have you, or any of your family members, ever had convulsions, seizures or epilepsy?	NO	YES
12. Do you have any long-term health problems such as heart or lung disease, kidney disease or metabolic disease (such as diabetes)?	NO	YES
13. Do you, or anyone else at home, have cancer, leukemia, lymphoma, HIV/AIDS or any immune system problem (inability to fight infection)?	NO	YES
14. Are you, or any one else at home, receiving chemotherapy, radiation therapy or steroid therapy (prednisone or cortisone)?	NO	YES
15. Do you have a family history of immune system problems?	NO	YES
16. Do you have close contact with anyone who has a severely weakened immune system (for example an individual who has had a bone marrow transplant and is currently in a hospital isolation room)?	NO	YES
17. Does your child have a history of intussusception (an uncommon type of bowel obstruction) or any ongoing digestive system problems?	NO	YES
18. Do you have asthma or have you had a recent episode of wheezing in the past 12 months?	NO	YES
19. Are you a current smoker?	NO	YES

I have read, or have had explained to me, the information contained in the Vaccine Information Statement(s) regarding the vaccine(s) to be administered today. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the specific vaccine(s) and I ask that the vaccine(s) be given to me, or to the person for whom I am authorized to make this request. I also authorize the Macomb County Health Department to release my immunization information record, or the immunization record of the person for whom I am authorized to make this request, to appropriate school/child care center personnel or other health care provider(s) as needed.

_____ _____

Signature of person to be vaccinated or person authorized to make request Date

FOR OFFICE USE ONLY

MEDICAL SCREENING/NURSES NOTES: _____

_____

_____

VIS(S) GIVEN: **DTaP/DT**___ IIV___ **HepA**___ **HepB**___ **HIB**___ **HPV**___ **IPV**___ LAIV4 ___ **MCV4/MPSV4**___ **MMR**___

MenB___ MMRV___ **PCV13**___ **PP23/P23V**___ **RV**___ **Td**___ **Tdap**___ **VAR**___ **ZV**___ **Multi** ___**(inc DTAP/HIB/HEB/IPV/PCV)**

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