

Fort Collins Youth Clinic

Immunization Screening Questions

Child's Name _____ Date of Birth _____

- If parent answers "no" to all these questions, immunize the child
- If parent answers "yes" to any question, consult with a Provider or refer to "Guide to Contraindications to Childhood Vaccines."

- | | YES | NO |
|--|-------|-------|
| 1. Is your child sick today or does your child have a high fever? | _____ | _____ |
| 2. Is your child or anyone in your household taking cortisone, prednisone, or other steroids, x-ray treatments, or chemotherapy? | _____ | _____ |
| 3. Does your child or anyone in your home have cancer, leukemia, HIV, AIDS, or other immune system problems? | _____ | _____ |
| 4. Did your child ever have a reaction to an immunization which was so bad you had to go to the doctor or hospital? | _____ | _____ |
| 5. Does your child have a neurological problem, that is, problems affecting his/her brain or nerves? Has a brother or sister or parent ever had convulsions or seizures? | _____ | _____ |
| 6. Does your child have allergy to eggs or to neomycin or streptomycin, which is so severe that it needs medical treatment? | _____ | _____ |
| 7. Has your child had a blood transfusion or immune globulin in the past year? | _____ | _____ |
| 8. Adolescents/adults to be immunized: Are you pregnant or do you intend to become pregnant within the next three months? | _____ | _____ |

Parent's/Guardian's Name _____

Parents'/Guardian's Signature _____

Date _____