

CHILD IMMUNIZATION QUESTIONNAIRE

Date: ___/___/___ Name - Last: _____ First: _____ MI: _____
 Address: _____ City: _____ State _____ Zip _____
 Phone # _____ Birth Date: ___/___/___ Age: ___ Sex: Male Female
 Social Security # _____

Ethnicity: Hispanic or Latino Non Hispanic or Latino
ace: Amer.Indian/Alaskan Native Asian White Black/African Amer. Native Hawaiian or Other Pacific Islander

Patient/Guardian Name (Print) Last: _____ First: _____ MI: _____

I have been given a copy and have read, or had explained to me, the information in the "Vaccine Information Statement(s)," where applicable, for the vaccine(s) indicated below. I have had a chance to ask questions and had them answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) currently due for which I have signed below be given to me or to the person named above for whom I am authorized pursuant to Section 431.058, RSMo to make this request.

Parent/ Guardian Signature: _____ Date: _____

1.	Does the person receiving the vaccine:	Circle correct response	
a)	currently have an illness more serious than a cold (fever, ear infection, diarrhea, vomiting)?	YES	NO
b)	have contact with someone who is HIV positive?	YES	NO
c)	have contact with someone who is receiving treatment for cancer or who has deficiency of the immune system?	YES	NO
d)	have a personal or family history of convulsions, seizures, tuberculosis or Guillan-Barre Syndrome	YES	NO
e)	have contact with someone who has not had any vaccinations?	YES	NO
2.	Has the person receiving the vaccine:		
a)	had a reaction to a vaccine other than redness, soreness and swelling in the injection site?	YES	NO
b)	taken a drug that affects the immune system (such as immune globulin or steroids) in the last 3-6 months?	YES	NO
c)	had an allergic reaction to:		
	a medication (name of medication _____)	YES	NO
	thimerosal (a preservative)	YES	NO
	latex	YES	NO
	Eggs/chicken	YES	NO
	gelatin	YES	NO
	Flu shot	YES	NO
d)	had a high fever or other serious reaction to a previous dose of vaccine?	YES	NO
e)	tested positive for HIV?	YES	NO
f)	ever had Chicken Pox (Varicella)? Actual disease or Vaccine	YES	NO
3.	Is the person receiving the vaccine pregnant?	YES	NO
4.	Has the person being immunized received any vaccines in the last month?	YES	NO

Nurse Use Only

immunization status reviewed.
 No true contraindications to vaccinations per Immunization questionnaire/interview
 Potential side effects reviewed. Encouraged to contact LCH with questions and concerns.
 Vaccination information statements given to parents
 Discussed dosage & use of Tylenol to manage side effects.
 Vaccines recorded on vaccination card.

Return _____

PER PROTOCOL ORDER SIGNED _____ DATE: _____