



# South River Pediatrics, LLC

"We care for kids"

Patient Name: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_

<b>Screening Questionnaire For Child and Teen Immunization</b>			
For parents/guardians: The following questions will help us determine which vaccines may be given today. If a question is not clear, please ask the nurse or doctor to explain it.			
	YES	NO	Don't Know
1. Is the child sick today? Vaccines will be postponed until acute phase of febrile and/or respiratory illness has passed at least 72 hours.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the child have allergies to any medications, food or vaccines, especially egg or egg products, gelatin or neomycin?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the child had a serious reaction to a vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the child had a seizure, inflammation of the brain (Encephalopathy) or history of Guillain-Barre Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Does the child have cancer, leukemia, AIDS, or any other immune system problem or Chronic Metabolic Disease (including Diabetes), renal function or Hemoglobinopathies, Congenital or Acquired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Has the child taken cortisone, prednisone, other steroids, or anticancer drugs or had x-ray treatments in the past 3 months? Is the patient on aspirin therapy or aspirin containing therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has the child received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Has the child received any vaccines or medications in the past 4 weeks? What vaccines or medications?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Does the patient have any underlying medical condition/chronic disorder of Cardiovascular and/or pulmonary system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Does the patient have a history of asthma and/or reactive airway disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Does the patient have household or close contact with immunocompromised individuals? (Must stay away from that individual for at least 21 days for Intra-Nasal Flu or it is contraindicated.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Form Completed By: _____		Date: _____	
<p>Did you bring your child's immunization record card with you? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>It is important to have a personal record of your child's vaccinations. If you don't have a record card, ask the child's health care provider to give you one! Bring this record with you every time you seek medical care for your child. Make sure your health care provider records all your child's vaccinations on it. Your child will need this card to enter daycare, kindergarten, junior high, etc.</p>			