

Name: _____ Date of birth: ___/___/___ Age: ___
 Mailing Address: _____ City: _____ State: _____ Zip: _____
 Phone Number: _____ Email: _____
 Wyoming Resident? Yes ___ No ___ Insurance: Yes ___ No ___
 Name of Insurance: _____ Policy #: _____
 VFC Eligibility: Medicaid Uninsured Underinsured Insured American Indian/Alaska Native

Screening Questionnaire for <u>Child and Teen</u> Immunization			
For parent/guardian: The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your nurse to explain it.			
	Yes	No	Don't Know
1. Is the child sick today or does the child have a fever?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the child have allergies to medications, food, a vaccine component, or latex?	<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. If your child is a baby, have you ever been told he or she has had intussusception?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. In the past 3 months, has the child taken cortisone, prednisone, other steroids, or anticancer drugs? Has the child had radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. In the past year, has the child received a transfusion of blood or blood products, or been given immune globulin or an antiviral drug?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. 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"/>
10. Has the child received vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Acknowledgement of Receipt of Notice of Privacy Practices

I have received and read the Wyoming Department of Health Notice of Privacy Practices and have had a chance to ask questions about how my information will be used. **Client or Parent/Guardian's initials** _____

- By signing below, I give my permission to provide my infant or child (named above) with all current immunizations appropriate for his/her age.
- I have read the Vaccine Information Statement(s) for the vaccine(s) to be given today.
- A health care professional has provided education and counseling on each vaccine and I have had a chance to ask questions that were answered to my satisfaction.

Printed Name of Client or Parent/Guardian _____ **Relationship to child** _____

Client or Parent/Guardian Signature _____ **Date** _____

Witness _____

IMMUNIZATIONS ADMINISTERED THIS VISIT:

VACCINE	LOT#	SITE/ROUTE	NURSE