CASPER/NATRONA COUNTY DISEASE PREVENTION

IMMUNIZATION SCREENING QUESTIONNAIRE FOR AGES 2 – 17 YEARS

Client's Name: ______________________________ Today's Date__________
First Middle Last

Sex: _____ Birthdate: ____________ Age: ____________ Home Phone: __________ Work Phone: __________

Street Address: ______________________ Mailing Address: ______________________

City: __________ State: _____ Zip: _____ School currently attending: ______________ Present grade: ________

Parent/Guardian: ______________________________ Physician: ______________

☐Wyoming Resident ☐Non Resident ☐Native American

☐KidCare/Chip ☐Medicaid/EqualityCare ☐Uninsured ☐Insured Insurance Name______________ Policy# ____________

General for All Immunizations

1. Is the minor allergic to **any** medications? If yes, what? ______________ .... YES NO
2. Are you the minor's parent or legal guardian? .... YES NO
   If not, has the parent or legal guardian given written consent (Must be notarized and attached)?
3. Does the minor have a fever or illness at this time? .... YES NO
4. Has the minor been diagnosed with a febrile illness? .... YES NO
5. Is the minor on chemotherapy, radiation treatments or taking steroids? .... YES NO
6. Is the minor receiving immunosuppressive therapy, including cortico-steroids? .... YES NO
7. Does the minor take anti-coagulants or have a blood clotting disorder? .... YES NO
8. Does the minor have a blood disorder or malignancy? .... YES NO
9. Does the minor have tuberculosis? .... YES NO
10. Is the minor taking any medications?
    If yes, what? ______________________ For? ______________________
11. Has the minor ever had a seizure or convulsion? .... YES NO
12. Is there a chance a female minor could be pregnant? .... NA YES NO
13. Have you ever had Chicken Pox? .... YES NO

DTAP, DPT, Dt, Td , Tdap (Diphtheria, Tetanus, Pertussis) **Suggested but patient refused** ☐

1. Has the minor ever had a severe reaction to the DTP, Dt or Td vaccine? .... YES NO
   Was there a fever of 102 or over when taken under the arm? .... YES NO
   Was there a fever of 103 or over when taken by mouth? .... YES NO
   Was there a fever of 104 or higher when taken rectally? .... YES NO
   Was there any unusual high-pitched crying within 48 hours,
   or persistent inconsolable crying for 3 or more hours after DTP vaccine? .... YES NO
2. Does the minor have any neurological disorders such as epilepsy, infantile spasms or progressive encephalopathy, etc? . YES NO
3. Does the minor have a wound? .... YES NO

Gardasil **Suggested but patient refused** ☐

1. Have you had an allergic reaction to a previous dose of Gardasil? .... YES NO
2. Are you planning to become pregnant in the next 6 months? .... YES NO

HboC (Haemophilus b Conjugate Vaccine) **Suggested but patient refused** ☐

1. Has the minor ever had a reaction to Diphtheria vaccine (contained in DTP, Dt and Td vaccines)? .... YES NO
2. Has the minor ever had a reaction to HboC vaccine? .... YES NO

Hepatitis A **Suggested but patient refused** ☐

1. Has the minor ever had a severe reaction to Hepatitis A vaccine? .... YES NO

Hepatitis B **Suggested but patient refused** ☐

1. Has the minor ever had Hepatitis B disease? .... YES NO
2. Is the minor allergic to yeast? .... YES NO
3. Has the minor previously received Hepatitis B vaccine? .... YES NO

IPV (Inactivated Polio Vaccine) **Suggested but patient refused** ☐

1. Does the minor have an allergy to streptomycin or neomycin? .... YES NO

MMR (Measles, Mumps, Rubella) **Suggested but patient refused** ☐

1. Does the minor have an allergy to neomycin or eggs? .... YES NO
2. Has the minor received blood transfusions or blood products, including immune globulin, within the last 3 months? .... YES NO
3. Did the minor have a reaction to a previous MMR? .... YES NO

Menactra, Menomune **Suggested but patient refused** ☐

1. Has the minor had a previous dose of meningitis vaccine? .... YES NO
2. Has the minor had a reaction to a previous dose of meningitis vaccine? .... YES NO
3. Has the minor had a history of Guillian-Barre Syndrome (Menactra)? .... YES NO
4. If previously vaccinated, was the minor under 4 years of age? .... YES NO

Pneumococcal Conjugate (Prevnar) **Suggested but patient refused** ☐

1. Has the minor ever had any pneumococcal vaccine? .... YES NO
2. Is the minor allergic to diphtheria toxoid? .... YES NO

Rotovirus **Suggested but patient refused** ☐

1. Has the minor had a reaction to a previous dose of rotovirus? .... YES NO
2. Does the minor have diarrhea or vomiting at this time or within the last 48 hours? .... YES NO
3. Does the minor have any digestive problems or a history of bowel obstruction (intussusception)? .... YES NO
4. Has the minor received blood transfusions or blood products, including immune globulin, within the past 3 months? ..... YES NO

TYP-I (Typhoid) **Suggested but patient refused** ☐

1. Has the minor had a Typhoid vaccination within the last 5 years? .... YES NO
2. Has the minor had a reaction to a previous dose of Typhoid vaccine? .... YES NO

VAR (Chicken Pox) **Suggested but patient refused** ☐

1. Has the minor ever had chickenpox? .... YES NO
2. Has the minor had a reaction to a previous dose of chickenpox vaccine? .... YES NO
3. Does the minor have an allergy to neomycin? .... YES NO
4. Does the minor have an immune system disorder? .... YES NO
5. Have you receive blood transfusions or blood products, including immune globulin, in the past 5 months? .... YES NO
6. Is the minor under 1 year old, or does he/she have close contact with newborns, pregnant women or immunocompromised persons? .... YES NO

YF (Yellow Fever) **Suggested but patient refused** ☐

1. Has the minor had a YF vaccination within the last 10 years? .... YES NO
2. Has the minor had a reaction to previous YF vaccination? .... YES NO
3. Does the minor have an allergy to eggs or neomycin? .... YES NO
4. Has the minor received a blood transfusions or blood products, including immune globulin, within the last 8 weeks?...... YES NO

I have been given a copy and have read or have had explained to me the information on the Vaccine Information Sheet. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine. I request that the vaccination(s) marked be given to me or to the person named for whom I am authorized to make this request.

I give my consent to have this information put into the Wyoming Immunization Central Registry.

Signature ____________________ Date______________

I have reviewed a copy of the Wyoming Department of Health NOTICE OF PRIVACY PRACTICES and have had a chance to ask questions about how information will be used. Please initial ___________.

I have been informed that my insurance company will be billed per my request, but if charges are applied to my deductible or denied due to my policy not covering this/these service(s), I will be billed. Please Initial__________.

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

Date ____________ Signature of Parent of Legal Guardian ____________ Signature of Clinic Nurse ____________

DATE	VACCINE	DOSAGE	SITE/ ROUTE	MFG/LOT#	NURSE	VIS DATE	COMMENTS