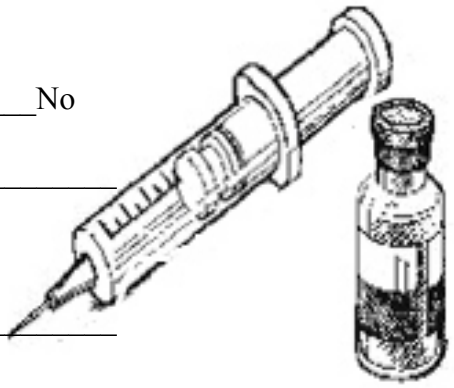
PATIENT'S NAME: _____ DOB: _____ CHART #: _____

SCREENING QUESTIONAIRE FOR INFANTS, CHILDREN, AND TEENS

The following questions will help us determine which vaccines may be given to your child today.
If any questions are unclear, please ask for ask for an explanation.



1. Does your child presently have a moderate or severe illness today? _____ No

2. Does your child have allergies to medications, food, latex, or any vaccine? _____No

   _____Yes: _____

3. Has your child had a serious reaction to a vaccine in the past? _____No

   _____Yes: _____

4. Has your child had a seizure or a brain problem? _____No

   _____Yes: _____

5. Does your child/family member have cancer, leukemia, AIDS, or any other immune system problem? _____No

   _____Yes: _____

6. Has your child had prednisone/steroids, anticancer drugs, or x-ray treatments in the past 3 months? _____No

   _____Yes: _____

7. Has the child received a transfusion of blood, blood products, or immune globulin in the past year? _____No

   _____Yes: _____

8. Is the patient pregnant or is there any chance she could become pregnant during the next month? _____No

9. Has the child received any vaccines anywhere else? _____No

   _____Yes: _____

Parent/guardian: _____ Date: _____

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Parent/guardian: _____ Date: _____