



CLAY COUNTY
PUBLIC HEALTH CENTER



Dear 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.

Child's Name: _____ **Date of Birth:** _____

1. Does the child have allergies to medications, food, a vaccine component, or latex? **YES or NO**
If **YES**, please explain. _____
2. Has the child ever had a serious reaction to a vaccine in the past? **YES or NO**
If **YES**, please list what vaccine and reaction. _____
3. Does the child have any long-term health problems with heart, lung (including asthma), kidney, liver, nervous system, or metabolic disease (e.g., diabetes), a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are they taking regular aspirin or salicylate medication? **YES or NO**
If **YES**, please explain. _____
4. Has the child, a sibling, or a parent ever had a seizure? Has the child had any brain or nervous system problems? **YES or NO**
If **YES**, please explain. _____
5. Does the child have an immune-system problem such as cancer, leukemia, HIV/AIDS? **YES or NO**
If **YES**, please explain. _____
6. For babies: Have you even been told the child has intussusception? **YES or NO**
7. Has the child ever been diagnosed with a heart condition (myocarditis or pericarditis), or have they had Multisystem Inflammatory Syndrome (MIS-C) after an infection with the virus that causes COVID-19? **YES or NO**
If **YES**, please explain. _____
8. In the past 6 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anti-cancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, psoriasis, or had radiation treatments? **YES or NO**
If **YES**, please explain. _____
9. Does the child's parent or sibling have an immune system problem? **YES or NO**
If **YES**, please explain. _____
10. In the past year, has the child received immune (gamma) globulin, blood/blood products, or an antiviral drug? **YES or NO**
If **YES**, please explain. _____

11. Has the child received any vaccinations in the last 4 weeks? **YES or NO**

If **YES**, which vaccines and when? _____

12. Is the child/teen pregnant? Any chance of pregnancy in the next 4 weeks? **YES or NO or NA**

13. Has the child ever felt dizzy or faint before, during, or after a shot? **YES or NO**

14. Is the child anxious about getting a shot today? **YES or NO**

15. To be answered on the day of clinic: Is the child sick today? **YES or NO**

If the nurse has additional questions during your child's immunization appointment, what is a good phone number where you can be reached: _____

What is your preferred language? _____

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ **Date:** _____