CHILD/TEEN IMMUNIZATION SCREENING QUESTIONNAIRE

I acknowledge that I have been given a copy and have read, or have had explained to me the information in the Vaccine Information Statement(s) and have received a copy of MultiCare Health System's Notice of Privacy Practice (NPP). I have had a chance to ask questions that were answered to my satisfaction. I understand the risks and benefits of the vaccine(s). I request that the vaccine(s) indicated be given to the child/adolescent named below for whom I am the parent or legal guardian, for whom I am authorized to make this request. I understand my child's immunization information is entered into an electronic database that can be shared with other providers/school personal.

(Please Print)

Parent/Guardian Name _____ Signature _____ Date _____

Child's Name : _____ Birth Date: _____ Age: _____ ❑M ❑F
(First) (Middle) (Last)

Address: _____
(Street Address) (City) (State) (Zip Code)

Phone: _____ Cell Phone: _____ Physician's Name: _____

ARE YOU
❑ Uninsured - No Insurance
❑ Privately Insured
❑ Children's Health Insurance Program (CHIP)
❑ Under Insured - Insurance doesn't cover immunizations
❑ Native American
❑ Alaska Native
❑ On or eligible for State Supported Insurance: Medicaid, Coupons, Healthy Options, Molina, Basic Health Plan

1. Is the child sick today? ❑ Yes ❑ No ❑ Don't Know
2. Does the child have allergies to medications, food, a vaccine component, or latex? ❑ Yes ❑ No ❑ Don't Know
3. Has the child had a serious reaction to a vaccine in the past? ❑ Yes ❑ No ❑ Don't Know
4. Does the child have a long-term health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Is he/she on long-term aspirin therapy? ❑ Yes ❑ No ❑ Don't Know
5. If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months? ❑ Yes ❑ No ❑ Don't Know
6. If your child is a baby, have you ever been told he or she has had intussusception? ❑ Yes ❑ No ❑ Don't Know
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems? ❑ Yes ❑ No ❑ Don't Know
8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem? ❑ Yes ❑ No ❑ Don't Know
9. Does the child have a parent, brother, or sister with an immune system problem? ❑ Yes ❑ No ❑ Don't Know
10. In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments? ❑ Yes ❑ No ❑ Don't Know
11. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? ❑ Yes ❑ No ❑ Don't Know
12. Is the child/teen pregnant or is there a chance she could become pregnant during the next month? ❑ Yes ❑ No ❑ Don't Know
13. Has the child received vaccinations in the past 4 weeks? ❑ Yes ❑ No ❑ Don't Know

DO NOT WRITE BELOW THIS LINE (Staff Only-Circle applicable information)

ROTAVIRUS	**HAEMOPHILUS (HIB)**	**PCV-13/ PPSV23*high risk**	**DTaP-IPV-Hep. B**	**DTaP-IPV**
Rota Teq	ActHib/Pedvax HIB	Prevnar/ Pneumovax*	Pediarix	Kinrix
Mfg. Merck	Mfg. Sanofi/Merck	Mfg. Wyeth	Mfg. GSK/Sanofi	Mfg. GSK
Lot#	Lot #	Lot #	Lot #	Lot #
Site: PO	Site: L R Vas. Lat.	Site: L R Vas. Lat.	Site: L R Del. Vas. Lat.	Site: L R Del. Vas. Lat.
Dose# 2.0 mL PO	Dose # 0.5 mL IM	Dose # 0.5 mL IM	Dose # 0.5 mL IM	Dosage: 0.5 mL IM
VIS date:	VIS date:	VIS date:	VIS date:	VIS date:
IPV	**HEPATITIS A**	**HEPATITIS B**	**MMR**	**VARICELLA / MMRV**
Ipol	Havrix/VAQTA	Recombivax/Engerix	MMR II	Varivax / ProQuad
Mfg. Sanofi	Mfg. GSK/Merck	Mfg. Merck/GSK	Mfg. Merck	Mfg. Merck
Lot #	Lot #	Lot #	Lot #	Lot #
Site: L R Arm Leg	Site: L R Del. Vas. Lat.	Site: L R Del. Vas. Lat.	Site: L R Arm Leg	Site: L R Arm Leg
Dose # 0.5 mL SQ/IM	Dose# 0.5 mL IM	Dose# 0.5 mL IM	Dose # 0.5 mL SubQ	Dose # 0.5 mL SubQ
VIS date:	VIS date:	VIS date:	VIS date:	
DTaP /DT/ Td / Tdap/	**MCV - 4**	**HPV9**	**INFLUENZA**	**DTAP-IPV-HIB / MEN B**
Infanrix/DT/Tenivac/Boostrix	Menactra/Meneveo	Gardasil 9	Name:	Pentacel /Bexsero
Mfg. Sanofi/GSK	Mfg: Sanofi/Novartis	Mfg. Merck	Mfg.:	Mfg:Sanofi /GSK
Lot #	Lot #:	Lot #	Lot#	Lot#
Site: L R Del. Vas. Lat.	Site: L R Deltoid	Site: L R Deltoid	Site: L R Del Vas. Lat. Nas.	Site: L R Del V as Lat
Dose # 0.5 mL IM	Dose # 0.5 mL IM	Dose # 0.5 mL IM	Dose# 0.25ml 0.5ml 0.2ml	Dose# 0.5ml IM
VIS date:	VIS date:	VIS date:	VIS date:	VIS date:

Vaccine Administrator: _____ Date: _____

Patient Identification - Always Attach Patient Label

Name:

MRN #:

CSN #:

Age / Sex and Gender:

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MultiCare

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