Wayne County Health Department
Screening Questionnaire for Immunizations

Screening Questions for all vaccines (Circle Yes or No for each question) Explain "Yes" answers below.			
Are you sick today?		**YES**	**NO**
Do you have any allergies or have you had any serious or life threatening reactions (anaphylaxis, difficulty breathing, etc.) to any foods, medications, or vaccines? (i.e.: eggs, gelatin, latex, etc.)		**YES**	**NO**
Do you have a history of seizures, Guillain-Barre Syndrome, or any other neurological conditions?		**YES**	**NO**
Do you have any medical conditions that weaken the immune system? (cancer, leukemia, AIDS, autoimmune disorders, etc.)		**YES**	**NO**
Do you take any medications or receive any treatments that affect your immune system? (i.e.: cortisone, prednisone, steroids, anti-cancer drugs, radiation treatments, etc.)		**YES**	**NO**
Have you received a transfusion of blood, plasma, or immune globulin in the last year?		**YES**	**NO**
Have you been treated for wheezing or diagnosed with asthma within the last 12 months?		**YES**	**NO**
Would you like a copy of the Wayne County Health Department Privacy Policy?		**YES**	**NO**
Are you pregnant? **NO** **YES** # of weeks _____	Are you breastfeeding?	**YES**	**NO**
I would like a referral to: (circle one if interested)		**WIC**	**CMH**
Screening Questions for COVID vaccine. **(Answer the following questions also <u>if you are receiving your COVID vaccine</u>)**			
Have you tested positive for COVID-19 or had a doctor tell you that you have COVID-19, in the last 3 months?		**YES**	**NO**
Have you been treated with antibody therapy (monoclonal or convalescent plasma) for COVID-19 infection within the last 90 days (3 months)? If "YES" write dates below.		**YES**	**NO**
Have you ever been diagnosed with pericarditis or myocarditis?		**YES**	**NO**
Has it been at least 60 days (2 months) since your last COVID vaccine?		**YES**	**NO**

<u>Explain any "YES" answers from above:</u>

_____

_____

<u>CONSENT</u>

I have read the information on the Vaccine Information Sheet (VIS) that has been given to me for each vaccine that I will be receiving today. I am aware of the risks and benefits associated with each vaccine that is to be administered to myself or the person for whom I am authorized to speak for as parent or guardian. I have had an opportunity to ask questions and have had all questions answered to my satisfaction. I have been offered a copy of the Wayne County Health Departments' Notice of Privacy Practices.
I grant permission for this record to be released to my medical provider, school, day care center, WIC, or other health departments and the state immunization registry, as is required or necessary.

Patient Printed Name: _____ Date: _____

Patient/Guardian Signature: _____ Relationship: _____

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_____ I have reviewed all immunization history to determine which vaccines are indicated for the client.

_____ I have reviewed the screening questionnaire and no contraindications have been found for the vaccines being administered.

Comments: _____

Nurse Signature: _____ Date/Time: _____