# FREMONT COUNTY DEPARTMENT OF PUBLIC HEALTH & ENVIRONMENT

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## Immunization Screening Questionnaire & Consent Form

Patient Name: _____ Date of Birth: ____/____/_____

The following questions are required and are used to help us determine which vaccines may be given today. Please circle your response to each question asked. If you answer "yes" to any question, it does not necessarily the patient should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

*We recommend that you check with your health plan prior to receiving any medical services to assess your benefits and eligibility for coverage*

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| 1. | Is the patient ill today or have a fever? | Yes / No |
| 2. | Has the patient ever had a serious reaction after receiving a vaccine? | Yes / No |
| 3. | If the patient is a child 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 / NA |
| 4. | If the patient is a baby, have you ever been told he or she has had intussusception? | Yes / No / NA |
| 5. | Does the patient have an allergy to any medication, latex or a vaccine component? | Yes / No If yes: _____ |
| 6. | Does the patient have an allergy to food, egg or egg product? | Yes / No If yes: _____ |
| 7. | Does the patient have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder? | Yes / No If yes: _____ |
| 8. | Does the patient have cancer, leukemia, HIV/AIDS, or any other immune system problem? | Yes / No If yes: _____ |
| 9. | In the past 3 months, have the patient 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 have you had radiation treatments? | Yes / No If yes: _____ |
| 10. | During the past year, has the patient received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? | Yes / No If yes: _____ |
| 11. | Has the patient had a seizure or a brain or other nervous system problem? | Yes / No If yes: _____ |
| 12. | Has the patient ever had Guillain-Barre Syndrome? | Yes / No |
| 13. | Is the patient pregnant or is there a chance she could become pregnant during the next 4 weeks? | Yes / No / NA |
| 14. | Has the patient received any vaccinations in the past 4 weeks? | Yes / No |

**You should <u>NOT</u> receive the influenza vaccine if any of the following apply:**

- You have ever had a serious allergic reaction to eggs or to a previous dose of influenza vaccine
- You have a history of Guillain-Barre Syndrome (GBS)
- You are ill

**The following puts patients at higher risk for contracting Hepatitis A:**

- Traveling to countries that have high rates of Hepatitis A
- Men who have sexual contact with other men
- People who live with or have sexual contact with someone who has Hepatitis A
- Users of injection or non-injection illegal drugs
- People who have chronic liver disease
- People who are treated with clotting-factor concentrates
- People who work with Hepatitis A infected animals or in a Hepatitis A research laboratory

**By signing below I hereby authorize Fremont County Department of Public Health & Environment to bill my insurance for reimbursement and request that payment of authorized benefits be made to Fremont County Department of Public Health & Environment. I attest that the above information is true and complete to the best of my knowledge, and I am aware that deliberate misrepresentation may jeopardize my health.** I have been given a copy and have read the information in the Vaccine Information Sheet for each vaccine checked below. I have had a chance to ask questions and they were answered to my satisfaction. I understand the benefits and risks of each vaccine requested and ask that the vaccine(s) checked below be given to me or to my child, _____Name of Minor Child_____, for whom I am authorized to make this request.

☐ Hep B ☐ Hep A ☐ HIB ☐ Polio ☐ PCV ☐ MMR ☐ Meningococcal ☐ Rotavirus

☐ Dtap ☐ DT pediatric ☐ Tdap ☐ Td adult ☐ HPV ☐ Varicella ☐ Influenza ☐ Other_____

I understand the vaccine will not be fully effective for approximately two weeks; However as with all vaccines there is no guarantee that I will become immune or that I will not experience side effects. I understand that one should not receive the influenza vaccine if they have a severe allergy to eggs, have had a severe reaction to a previous influenza vaccine, or if they have had Guillain-Barre Syndrome.

_____ _____ _____

Signature of Patient/Parent/Legal Guardian | Printed Name/Relationship | Date

** A consent must be signed in order for a patient to receive an immunization. For children under 18 the consent will be signed by the parent or legal guardian.*

# For Clinical Use Only

| Patient Eligibility | | | | | | |
|---|---|---|---|---|---|---|
| □ Medicare | □ Medicaid | □ Private | □ 317 | □ VFC | □ Underinsured | □ Uninsured |

| Vaccine Information | | | | | |
|---|---|---|---|---|---|
| **Vaccine** | **Dose** | **Site** | **Route** | **VIS Date** | **Manufacturer Lot #** |
| | 0.5mL 0.7mL 1.0mL 1 2 3 4 5 | | | | |
| | 0.5mL 0.7mL 1.0mL 1 2 3 4 5 | | | | |
| | 0.5mL 0.7mL 1.0mL 1 2 3 4 5 | | | | |
| | 0.5mL 0.7mL 1.0mL 1 2 3 4 5 | | | | |
| | 0.5mL 0.7mL 1.0mL 1 2 3 4 5 | | | | |
| | 0.5mL 0.7mL 1.0mL 1 2 3 4 5 | | | | |

_____ _____

Signature of Vaccine Administrator Date

| Billing Information | |
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| Notes |
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