METRO CARE CONNECTION
Healthy Students ▪ Healthy Schools
Cedar Rapids Community School District
School-Based Health Centers & Services

Immunization Screening Questionnaire

Patient Name _____ Complete date of birth_____

For parents and guardians: This form helps us decide which vaccines should be given today. Please answer the questions by checking the boxes.

	Yes	No	Don't know
1.Does your child have a fever or illness today?	☐	☐	☐
2.Does the child have any allergies to eggs, streptomycin, neomycin, gelatin or baker's yeast?	☐	☐	☐
3.Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
4.Has the child had a seizure or a changing neurological disorder?	☐	☐	☐
5. Does the child have a disease or take medication(like steroids) or take treatments which make it difficult for the body to fight off infections (such as cancer, HIV, gamma globulin deficiency, etc.)?	☐	☐	☐
6. Does someone with whom the child lives (or has close contact) have a disease, take medication, or take treatments which makes it difficult for the body to fight off infections (such as cancer, HIV, leukemia, gamma globulin deficiency, etc.)?	☐	☐	☐
7. Has the child received blood, plasma, or gamma globulin in the past 6 months?	☐	☐	☐
8. Is the patient pregnant or at risk of becoming pregnant within the next 3 months?	☐	☐	☐
9. Has the child had chicken pox or received the chicken pox vaccine?	☐	☐	☐

Form completed by:_____ Date _____

Form reviewed by: _____ Date _____