

ADULT IMMUNIZATION HEALTH SCREENING
(19 years and over)

NAME	DOB	NO	YES	Nurse Use Only Contraindication
1. Are you sick today?				All
2. Do you have allergies to medications, food, a vaccine component, or latex?				All – see below
3. Have you ever had a serious reaction to a vaccine in the past?				All
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?				MMR, VAR
6. In the past 3 months, have you taken medications that affect your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?				MMR, VAR
7. Have you had a seizure or a brain or other nervous system problem?				Td, Tdap, Influenza
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?				MMR, VAR
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?				MMR, VAR
10. Have you received any vaccinations in the past 4 weeks?				MMR, VAR

NURSE USE ONLY 2. Eggs–Influenza Gelatin–MMR, VAR Neomycin–MMR, VAR, Hep A Yeast–Hep B, HPV Latex–Tdap

**Waupaca County Department of Health and Human Services – HIPAA
Acknowledgement of Receipt of Notice of Privacy Practices Regarding Health Information**

By signing this form, you acknowledge that Waupaca County Department of Health and Human Services has given you a copy of its Notice of Privacy Practices Regarding Health Information, which explains how your health information will be handled in various situations. All clients receiving services on or after April 14, 2003, will be asked to sign this form.

If your first date of service with Waupaca County Department of Health and Human Services was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as possible after the emergency.

By my signature below, I acknowledge I have received a copy of the Waupaca County Department of Health and Human Services' Notice of Privacy Practices Regarding Health Information and have been given an opportunity to discuss my concerns and questions.

Signature _____ Date _____

NURSE USE ONLY

Reviewed Common Side Effects	Private Pay Hep B () cash () check () Bill Employer _____
Gave Vaccine Information Sheet(s)	
Scheduled Next Appointment	
WIR Data Entry Completed	
PHN Initials	Date