## CHILD IMMUNIZATION HEALTH SCREENING

(18 years and under – VFC Program Guidelines)

| NAME | DOB | NO | YES | Nurse Use Only Contraindication |
|---|---|---|---|---|
| 1. Is the child sick today? | | | | All |
| 2. Does the child have allergies to medications, food, a vaccine component, or latex? | | | | All – see below |
| 3. Has the child had a serious reaction to a vaccine in the past? | | | | All |
| 6. If the child is a baby, have you ever been told that he or she has had intussusceptions? | | | | Rotavirus |
| 7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems? | | | | DTaP, Td, Tdap IIV |
| 8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem? | | | | MMR, RV, VAR |
| 9. 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? | | | | MMR, VAR |
| 10. 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? | | | | MMR, VAR |
| 11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month? | | | | MMR, VAR |
| 12. Has the child received vaccinations in the past 4 weeks? | | | | MMR, VAR |
| If the child has had chickenpox disease, list month/day/year. _____/_____/_____ | | | | |

**NURSE USE ONLY** 2. Eggs– Influenza Gelatin–MMR, VAR Neomycin–MMR, IPV, VAR, Hep A Streptomycin, Polymyxin B–IPV 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.

Parent/Guardian Signature_____ Date_____

**NURSE USE ONLY**

| | |
|---|---|
| Reviewed Common Side Effects | Parent/Guardian Refusal – List vaccine(s) |
| Gave Vaccine Information Sheet(s) | |
| Scheduled Next Appointment | |
| WIR Data Entry Completed | |
| PHN Initials | Date |