MARGARET MARY HEALTH

Occupational Health & Wellness Center
1051 State Road 229 N • Batesville, IN 47006
Phone: 812.932.5105

ONSITE HEALTH SCREENING FOR VACCINES

Child's Legal Name: _____ Age: _____ Date of Birth: _____

1. Does your child have any allergies to medications, foods or vaccines? *Mark any allergies:* ❒ **Yes** ❒ **No**

❒ Eggs ❒ Yeast ❒ Sulfa ❒ Penicillin
❒ Streptomycin ❒ Gelatin ❒ Latex ❒ Neomycin

❒ Other: _____

2. Has your child ever had a severe reaction to a vaccine in the past? *(i.e. temperature > 105˚, crying more than three hours)* **If yes, which vaccine and what was the reaction?** _____ ❒ **Yes** ❒ **No**

_____

3. In the past four weeks, has your child received any vaccinations or a tuberculin skin test? ❒ **Yes** ❒ **No**

4. Has your child ever had an unexplained seizure, brain or other nervous system problem, encephalopathy or Guillan-Barre syndrome. If yes, please explain: _____ ❒ **Yes** ❒ **No**

_____

5. For females - Is your daughter pregnant? *(Many vaccines should not be given to women known to be pregnant. Pregnancy should be avoided for four weeks following receipt of a live virus vaccine.)* ❒ **N/A** ❒ **Yes** ❒ **No**

6. Does your child have a weakened immunity due to a medical condition, medication or treatment? ❒ **Yes** ❒ **No**
Mark which apply:

❒ Cancer ❒ Stem cell transplant ❒ Radiation treatments
❒ Lymphoma ❒ Anti-tumor agents ❒ Anti-cancer medications
❒ Leukemia ❒ Low T-Lymphocyte count
❒ AIDS/HIV ❒ Crohn's/Psoriasis
❒ Large doses of cortisone, prednisone, other steroids (>20 mg/day for 2+ weeks)
❒ Taking medication for rheumatoid arthritis
❒ Malignant conditions affecting the bone marrow or lymphatic system
❒ Other: _____

7. In the past year, has your child received a transfusion of blood or blood products, been given immune gamma globulin or an antiviral drug. If yes, when: _____ ❒ **Yes** ❒ **No**

8. HPV (Gardasil) vaccine is highly recommended for males and females ages 9 through 45. This vaccine protects against genital warts and cervical cancer. For children ages 9 to 14, two doses are recommended separated by six months. For those 15 years old and older, three doses of the HPV vaccine are recommended at 0, 2 and 6 months. Would you like your child to receive this vaccine? ❒ **N/A** ❒ **Yes** ❒ **No**

9. Meningitis B - For 16 to 23 year olds. In June 2015, a new and additional meningitis vaccine containing serogroup B became available. This is an optional vaccine for high school students but required by **many Indiana colleges/universities**. The new meningitis vaccine is a series of two doses separated by approximately six months. Would you like your child to receive the Meningitis B vaccine? ❒ **N/A** ❒ **Yes** ❒ **No**

10. After reviewing your child's immunization record, all routine immunizations will be given to your child to meet state requirements. List any vaccine(s) you do NOT want your child to receive here: _____

_____

_____

Parent/Legal Representative Signature: _____ Date: _____
Printed Name: _____
Relationship to Patient: _____

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