Platte County Health Department
Serving Platte County Missouri
Student Screening Form

School Name:_______________________________________

Student Name:_____________________________________Student DOB:_________________________

Please answer questions about the person receiving the vaccine(s) by circling yes or no.

The following questions will help us determine which vaccines you may be given today. If you answer yes to a question, it does not necessarily mean you should not be vaccinated. It means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

1. Do you have allergies to medications, food, a vaccine component, or latex? Yes No
   If yes, what is your student allergic to?______________________________ Reaction? ______________
2. Have you had a serious reaction to a vaccine in the past? Yes No
3. Do you have a health problem with lung, heart, kidney, or metabolic disease (i.e., diabetes), asthma, or a blood disorder? Yes No
   If you are on aspirin therapy, please explain: ____
4. Have you ever had a seizure, or had a brain or other nervous system problem? Yes No
5. Do you have or live with someone who has cancer, leukemia, HIV/AIDS, or immune system problems? Yes No
6. In the past 3 months, have you 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? Yes No
7. In the past year, have you received a blood transfusion or blood products, or have been given a medicine called immune (gamma) globulin or an antiviral drug? Yes No
8. Have you received any vaccinations in the past 4 weeks? Yes No
9. Did you bring your immunization record with you? Yes No
   Additional Questions for Females Only:
10. Are you nursing, pregnant, or is there a chance you could become pregnant during the next month? Yes No
    If already pregnant, how many weeks?: ____________________
11. Are you currently using a birth control method? Yes No
12. To be answered the day of clinic: Are you sick today? Yes No

FORM COMPLETED BY:________________________________DATE:_________

FORM REVIEWED BY:_________________________________DATE:_________

Nurse Signature ______________________ Patient/Parent/Guardian Signature ______________________

---FOR CLINIC NURSE USE ONLY---

Circle Vaccine Source: VFC PCHD

VIS Given	Vaccine	Manufacturer	Lot #	Exp. Date	Site	Nurse Signature