



# Orchard Pediatrics, P.C.

## SCREENING QUESTIONNAIRE FOR TODAY'S IMMUNIZATIONS

**For parents and guardians:** This form helps us decide which vaccines should be given in our office today. If the question is not clear, please ask the nurse or doctor for an explanation.

- |   | Yes                   | No                    | Unknown               |
|---|-----------------------|-----------------------|-----------------------|
| 1. Is the child sick today with anything more than a cold?  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. Does the child have allergies to medications, yeast, eggs, latex or any previous vaccines?   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. Has the child had a serious reaction to a vaccine in the past?   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 4. Has the child had a seizure or a changing neurological disorder?   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 5. Does the child have cancer, an immune system disorder, or does the child take medications that suppress the immune system such as steroids (by mouth or injection) or anti-cancer drugs?                                 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 6. Does someone with whom the child lives (or has close contact) have cancer, an immune system disorder, or take medications that suppress the immune system such as steroids (by mouth or injection) or anti-cancer drugs? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 7. Has the child received blood, plasma, or gammaglobulin the past six months?  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 8. Is the patient pregnant or at risk of becoming pregnant within the next three months?  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

I have read, or have had explained to me, the information about the vaccine(s) listed above (VIS). I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) listed above are given to me or to the person below for whom I am authorized to make this request. I authorize you to submit all vaccine dates to the Michigan Childhood Immunization Registry.

**PATIENT INFORMATION:**

ACCT# \_\_\_\_\_

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_

SIGNATURE \_\_\_\_\_ RELATIONSHIP TO CHILD \_\_\_\_\_ DATE \_\_\_\_\_

FOR OFFICE USE	SITE	MANUF.	LOT#	NURSE	VIS DATE
DTaP					
IPV					
HIB					
HEP B					
MMR					
PREVNAR					
VARICELLA					
HEP A					
MMRV					
ROTATEQ					

Vaccines have a very short shelf life once prepared, and have to be discarded if not used. I realize that in signing this consent, the vaccines will be prepared especially for my child. If after the nurse prepares the vaccines, I elect NOT to have my child receive them, I agree to be financially responsible for the vaccine charges.

SIGNATURE \_\_\_\_\_ RELATIONSHIP TO CHILD \_\_\_\_\_ DATE \_\_\_\_\_