MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT *(Title and Number)*	ISSUANCE DATE **10-12**

LOCAL FORM TITLE **PEDIATRIC IMMUNIZATION SCREENING QUESTIONNAIRE**

1. Is your child ill with a fever today?	☐ Yes	☐ No	☐ Don't Know
2. Does your child have allergies to medications, food, any vaccine, or latex? Please List:_____	☐ Yes	☐ No	☐ Don't Know
3. Has you child received any vaccinations within the past 4 weeks?	☐ Yes	☐ No	☐ Don't Know
4. Has your child had a serious reaction to a vaccine in the past?	☐ Yes	☐ No	☐ Don't Know
5. Has your child had a health problem with lung disease, heart disease, kidney disease, diabetes, or a blood disorder?	☐ Yes	☐ No	☐ Don't Know
6. Has your child, sibling, or parent had a seizure or has the child had a brain or other nervous system problem?	☐ Yes	☐ No	☐ Don't Know
7. Has your child taken cortisone, prednisone, other steroids, chemotherapy or radiation therapy in the last 3 months?	☐ Yes	☐ No	☐ Don't Know
8. Does your child have cancer, leukemia, lymphoma, AIDS, or any other immune system problems?	☐ Yes	☐ No	☐ Don't Know
9. During the past 11 months, has your child received a transfusion of blood or been given a medicine called immune (gamma) globulin?	☐ Yes	☐ No	☐ Don't Know
10. Did your child have the following symptoms after DTaP or DTP immunization? a) Fever of 105 degrees Fahrenheit (40 degrees Celsius) within 48 hrs of a previous dose.	☐ Yes	☐ No	☐ Don't Know
b) Seizure within 3 days of previous dose.	☐ Yes	☐ No	☐ Don't Know
c) Continuous crying for 3 hours within 48 hrs of a previous dose.	☐ Yes	☐ No	☐ Don't Know
d) Pale, limp, or excessive sleepiness within 48 hrs of a previous dose.	☐ Yes	☐ No	☐ Don't Know
11. Is your child/teen pregnant or is there a chance she could become pregnant in the next 3 months?	☐ Yes	☐ No	☐ Don't Know

If any questions 1 through 11 is answered **"YES"**, the child's health care provider will be contacted first; if the child has not recently been evaluated by a PCM, such evaluation will be required prior to administration of the immunization. **PCM signature:** _____

Parent / guardian received and understands the vaccine information statements (VIS) for the given immunization/s. Signature below constitutes your permission for the NAVHOSP OAK HARBOR staff to administer the indicated vaccines.

Signature of Parent / Legal Guardian:_____ **Date:** _____

Vaccine administered by: _____

DTaP 1 2 3 4 5 **IPV** 1 2 3 4 **VAR** 1 2 **HIB** 1 2 3 4 **MMR** 1 2 **HEP B** 1 2 3 **PCV13** 1 2 3 4

TDaP **MGC** **KINRIX** **MMRV** **Hep A** 1 2 **Rota** 1 2 3 **Rediatrix (DTap, IPV, Hep B)** 1 2 3 **HPV** 1 2 3

PPD Given : **Date PPD read:** **PPD Results:** NEG / POS _____**mm** **Reader Signature:**

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	