SCREENING QUESTIONNAIRE

Section 1: Pediatric Vaccine Screening Questions

Directions for filling out Section 1 & 1b: Please circle an answer to each question if you are electing to have Dakota County Public Health administer immunizations to your child. If this is inapplicable, please skip to Section 2.

Yes	**No**	Does the child have a fever or illness today (Fever of 100.5 or higher? If yes, describe:
Yes	**No**	Does the child have any allergies to medications, food (including eggs), or latex? If yes, list:
Yes	**No**	Has the child had a serious reaction after receiving a vaccination, including flu or COVID-19 vaccination? If yes, describe:
Yes	**No**	Has the child, the patient's sibling, or the patient's parent had seizures, or other nervous system problems? If yes, list:
Yes	**No**	Has the child had chickenpox disease? If yes, provide exact date
Yes	**No**	Does the child have chronic health problems, such as lung disease, diabetes, asthma or a blood disorder? If yes, list:
Yes	**No**	**Only for infants:** Have you ever been told the patient has had intussusception?
Yes	**No**	Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?
Yes	**No**	In the past 3 months, has the child taken medications that affect the immune system, such as prednisone, steroids, drugs for anticancer, rheumatoid arthritis, Crohn's disease, psoriasis; or radiation treatments? Describe:
Yes	**No**	Has the child ever had Guillain-Barre Syndrome?
Yes	**No**	Has the child had a transfusion of blood/blood products, solid organ transplant, immune (gamma) globulin, or an antiviral drug in the past year? If yes, describe:
Yes	**No**	Has the child ever been diagnosed with a heart condition (myocarditis or pericarditis) or have they had a Multisystem Inflammatory Syndrome (MIS-C) after an infection or vaccination of COVID-19? If yes explain:
Yes	**No**	Does the child have a history of thrombosis, thrombocytopenia (TTS) or Heparin-induced thrombocytopenia (HIT)
Yes	**No**	Has the child had any vaccinations in the past 4 weeks? If yes, list them:
Yes	**No**	Has the child had a TB skin test (Mantoux) in the past 3 days or planning to have one in the next 4 weeks?
Yes	**No**	**For female clients:** Is the patient pregnant now or planning to become pregnant in the next month?
Yes	**No**	Is the child planning to travel outside the United States in the next 3 months?

Section 1b: Pediatric Screening Questions

FluMist (Nasal) Flu Screening Questions: Must be 2-49 years and NOT pregnant.

If this is inapplicable, please skip to Section 2

Yes	**No**	Does the child have any chronic health conditions, including diabetes, asthma, blood disorder, heart disease, lung disease, kidney disease, neurologic disorder, or liver disease?
Yes	**No**	Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem; or, in the past 3 months, taken medications that affect the immune system, such as prednisone, other steroids, or drugs to treat rheumatoid arthritis, Crohn's disease, psoriasis, or anticancer drugs; or have radiation treatments?
Yes	**No**	Is the child age 2 through 17 years and receiving aspirin therapy or aspirin-containing therapy?
Yes	**No**	Is the child a child age 2 through 4 years, and in the last 12 months experienced wheezing or asthma?
Yes	**No**	Is the child receiving flu antiviral medications (like Relenza or Tamiflu)?
Yes	**No**	Has the child received MMR, varicella, MMRV, shingles or yellow fever vaccinations in the past 4 weeks?
Yes	**No**	Does the child have a weakened immune system, or do you expect to have close contact with someone whose immune system is severely compromised and/or must be in protective isolation?

SCREENING QUESTIONNAIRE

Section 2: Adult Vaccine Screening Questions

Directions for filling out Section 2 & 2b: If you are 18 years or older and/or a legal guardian or authorized representative of the client, please circle an answer to each question if you are electing to have Dakota County Public Health administer immunizations to you and/or the client.

Yes	**No**	Do you have a fever or illness today (Fever of 100.5 or higher)?: If yes, describe:
Yes	**No**	Do you have any allergies to medications, food (including eggs), or latex? If Yes, list:
Yes	**No**	Have you had a serious reaction after vaccination, including flu and COVID-19 vaccination? If Yes, describe:
Yes	**No**	Have you had a seizure or a brain or other nervous system problem? If yes, list:
Yes	**No**	Do you have a history of chickenpox disease? If Yes, provide exact date?
Yes	**No**	Do you have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy? If yes, list:
Yes	**No**	Do you smoke cigarettes? (Additional vaccination may be recommended)
Yes	**No**	Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?
Yes	**No**	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 have had radiation treatments?
Yes	**No**	Have you ever had Guillain-Barre Syndrome
Yes	**No**	Have you had a transfusion of blood/blood products, solid organ transplant, immune (gamma) globulin, or an antiviral drug in the past year? If Yes, describe:
Yes	**No**	Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection or vaccination of COVID-19?
Yes	**No**	Have a history of thrombosis, thrombocytopenia (TTS) of Heparin-induced thrombocytopenia (HIT)
Yes	**No**	Have you had any vaccinations in the past 4 weeks? If yes, list them:
Yes	**No**	Have you had a TB skin test (Mantoux) in the past 3 weeks or plan to have one in the next 4 weeks?
Yes	**No**	For women: Are you pregnant now or planning to become pregnant in the next month?
Yes	**No**	Are you planning to travel outside the United States in the next 3 months?

Section 2b: Adult FluMist (Nasal) Screening Questions: Must be Age 2-49 and NOT pregnant

Yes	**No**	Do you have any chronic health conditions, including diabetes, asthma, blood disorder, heart disease, lung disease, kidney disease, neurologic disorder, or liver disease?
Yes	**No**	Do you have Guillain-Barré Syndrome, cancer, leukemia, HIV/AIDS, or any other immune system problem; or, in the past 3 months, taken medications that affect the immune system, such as prednisone, other steroids, or drugs to treat rheumatoid arthritis, Crohn's disease, psoriasis, or anticancer drugs; or have radiation treatments?
Yes	**No**	Are you receiving flu antiviral medications (like Relenza or Tamiflu)?
Yes	**No**	Have you received MMR, varicella, MMRV, shingles or yellow fever vaccinations in the past 4 weeks?
Yes	**No**	Do you have a weakened immune system, or do you expect to have close contact with someone whose immune system is severely compromised and must be in protective isolation?