

Vaccinate *before you* Graduate

Immunization Screening Questionnaire

Print Your Teen's Information Below

_____/_____/_____ **Male/Female**
 LAST FIRST DATE OF BIRTH: (MONTH/DATE/YEAR) Please circle

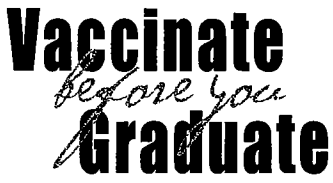
 STREET ADDRESS APT #

 CITY STATE ZIP CODE

Parent/Guardian: Please answer questions below to help us determine which vaccines may be given.	Yes	No	Don't Know
1. Does your child have allergies to medications, food, or any vaccine? If yes, explain:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Has your child had a serious reaction to a vaccine in the past? If yes, to what vaccine and when:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has your child had a seizure or brain problem? If yes, please indicate current status.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Does your child have leukemia, AIDS, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Does your child take cortisone, prednisone, other steroids, or anticancer drugs, or had an x-ray treatment in the past 3 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Has your child received a blood transfusion or blood products, or been given a medicine called immune (gamma) globulin in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has your child received any vaccinations in the past 4 weeks? If yes, which vaccine:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

 PARENT/GUARDIAN: PLEASE PRINT YOUR NAME YOUR DAYTIME PHONE NUMBER

 PARENT/GUARDIAN SIGNATURE



Influenza Vaccine Consent Form

I have received and read the Influenza (Flu) Vaccine Information Statements for two different types of influenza vaccine: 1.) Live Intranasal Flu vaccine (nasal spray); and 2.) Inactivated Flu Vaccine (shot). I understand the information about the Flu virus and I understand the benefits and risks of each different Flu vaccine. I give permission for my teen to receive the influenza vaccine circled below.

Please circle the vaccine of your choice:

1. Live Intranasal Vaccine (Nasal spray)

2. Inactivated Flu Vaccine (Flu shot)

Print Your Teen's Information Below:

_____/_____/_____
LAST FIRST MIDDLE DATE OF BIRTH: month/date/year

STREET ADDRESS APT # CITY STATE ZIP CODE

SCHOOL ATTENDING

Print Your Information Below:

Please print your name: _____

Signature of Parent or Guardian Date

Your daytime phone number: _____