Cereal City Pediatrics
there as they grow

4520 Beckley, Rd. Battle Creek, Mi 49015 269-969-8723

Today's Date: _____ Name: _____ DOB: _____

Vaccine screening questions:

Yes	**No**	
___	___	does your child have asthma or RAD (even mild)?
___	___	are they sick today?
___	___	does your child have any allergies to eggs, meds, vaccines?
___	___	does your child or direct family member have cancer, leukemia, AIDS, immune deficiency?
___	___	does your child or direct family member have diabetes, heart condition/problem?
___	___	does your child have seizures or other neurological problem?
___	___	are they on prolonged steroids, radiation therapy?
___	___	are they pregnant or possibly become pregnant in the next 1 month?
___	___	has your child had vaccines in the last 4 weeks?
___	___	has your child had blood or IVIG in the last 3 months?

If **yes** to any screening questions, please explain: _____

I have received and had an opportunity to read the vaccine information sheet on the vaccine my child will receive today.

Signature: _____

_____

Office use only

_____ Entered into patients chart
_____ Scanned into patients chart

Word: flu questions sheet