**Medical Screening Questionnaire and Consent for Vaccination**

*Please circle the answer to the following questions about you or the person to be vaccinated:*

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Ever had a serious reaction to a vaccine?</td>
</tr>
<tr>
<td>2.</td>
<td>Allergic to eggs, Thimerosal, gelatin, latex or any antibiotics?</td>
</tr>
<tr>
<td>3.</td>
<td>Receive an influenza vaccination during any past flu seasons?</td>
</tr>
<tr>
<td>4.</td>
<td>Ever had Guillain-Barré Syndrome (GBS)?</td>
</tr>
<tr>
<td>5.</td>
<td>Have any long-term health problem such as heart or lung disease, kidney disease or metabolic disease (diabetes)?</td>
</tr>
<tr>
<td>6.</td>
<td>Have severe thrombocytopenia (low platelet count) or a bleeding disorder?</td>
</tr>
<tr>
<td>7.</td>
<td>Currently ill or running a fever?</td>
</tr>
<tr>
<td>8.</td>
<td>Have asthma or have you/your child had a recent episode of wheezing in the past 12 months?</td>
</tr>
<tr>
<td>9.</td>
<td>Currently receiving aspirin therapy?</td>
</tr>
<tr>
<td>10.</td>
<td>Are or may be pregnant?</td>
</tr>
<tr>
<td>11.</td>
<td>Received any vaccine within the past 30 days?</td>
</tr>
<tr>
<td>12.</td>
<td>Have cancer, leukemia, lymphoma, or any immune deficiency disease (inability to fight infection) or currently receiving chemotherapy, radiation therapy or steroid therapy (prednisone or cortisone)?</td>
</tr>
<tr>
<td>13.</td>
<td>Have close contact with anyone who has a severely weakened immune system (for example, an individual who has had a bone marrow transplant and is currently in a hospital isolation room)?</td>
</tr>
</tbody>
</table>

I have read or have had explained to me, the information contained in the Vaccine Information Statement(s) regarding the vaccine(s) to be administered today. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the specific vaccine(s). I ask that the vaccine(s) be given to me, or to the person for whom I am authorized to make this request. I also authorize the Macomb County Health Department to release my immunization record information, or the immunization record information of the person for whom I am authorized to make this request to other health care provider(s) as needed.

**Macomb County Health Department Notice of Health Information Practices**

I have received a copy of Macomb County Health Department’s Notice of Health Information Practices. I understand that my acknowledgement of the Notice is evidenced by my signature on this document. The Department is required to abide by the terms of this privacy notice. The Department may change the terms of its notice at any time. The new notice will be effective for all protected health information that it maintains at that time. Upon my request, the Department will provide me with the revised notice of privacy practices.

Parent/Legal Guardian/Client Signature: X

SIGNATURE of Parent/Legal Guardian: ____________________________

PRINT NAME of Parent/Legal Guardian: ____________________________

__Received Notice of Health Information Practices__

__REFUSED written acknowledgement__

**Macomb County Health Department**

9-4-19 CHILD
**MCHD OFFICE STAFF USE ONLY**

Date of Service:_____________________

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**Medicare** _____ **Self Pay** _____ **MC (01)** _____ **Client ID** ________________

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**Medicaid** _____ **No Pay (Waived/250)** **WRN (02)** _____ **SCS (03)** _____ **(91/92/93)** Facility Zip Code ________________

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Does client have _____ **BCBS OF MICHIGAN** _____ **BCN** _____ **HAP** _____ **MCLAREN** _____ **PRIORTY** _____ **OTHER** ________________

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**Nurse Staff ID** ________________ **Nurse Confirmation of Client’s Birthdate:** ________________

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**Vaccine** | **Mfg/Lot#** | **Route** | **Site** | **VIS Date** | **VIS Given**
---|---|---|---|---|---
**FLVQ (IIV4) CP** | | **IM** RT LT RD LD | | 08/15/2019 | ___

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**FLQ (IIV4) CP** | | **IM** RT LT RD LD | | 08/15/2019 | ___

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**FLCX (ccIIV4) CP** | | **IM** RT LT RD LD | | 08/15/2019 | ___

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**FLBQ (RIV4) CP** | | **IM** RT LT RD LD | | 08/15/2019 | ___

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**FLMQ (LAIV4) State only** | | **IN** (intranasal) | **IN** | 08/15/2019 | ___

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**Next Date Due for Immunizations:** ______________________

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**Progress Notes:** ______________________

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Please copy MEDICAID Card/commercial insurance cards.