LENAWEE COUNTY
HEALTH DEPARTMENT

Pediatric Immunizations
Client Screening Form
Lenawee County Health Department
1040 S. Winter St. Suite 2328
Adrian MI 49221

Date: _____ Client Name: _____ Parent/Guardian Name: _____

Email: _____ Phone: _____ Text Reminders: ☐ Y ☐ N

Address: _____ City: _____State: _____Zip Code: _____

Date of Birth: _____ Age: _____ ☐ Male ☐ Female ☐ Transgender Other/Decline_____

Approximate Family yearly income: $_____ # of Household members _____

Race: ☐Arab ☐Asian ☐Black or African American ☐Chinese ☐Filipino ☐Hawaiian ☐Indian/Alaskan Native ☐Japanese ☐Multi-Racial ☐Pacific Islander ☐White ☐Other_____ ☐ Unknown

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown

SCREENING QUESTIONS			
1.	Is the Client sick today?	No	Yes
2.	Does the client have any allergies to food, medications, latex or vaccines (if yes, what)	No	Yes
3.	Has the child had a serious reaction to a vaccine in the past?	No	Yes
4.	Has the child, a sibling, or a parent had a seizure; has the child had a brain or other nervous system problem?	No	Yes
5.	Does the child have an immune-system problem such as cancer, leukemia, HIV/AIDS?	No	Yes
6.	In the past 6 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs to treat rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	No	Yes
7.	Have you ever been diagnosed with heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19?	No	Yes
8.	Does the child's parent or sibling have an immune system problem?	No	Yes
9.	In the past year, has the child received immune (gamma) globulin, blood/blood products, or an antiviral drug?	No	Yes
10.	For children age 2 through 4 years: Has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	No	Yes
11.	For babies: Have you ever been told that the child had intussusception?	No	Yes
12.	Is the child/teen pregnant?	No	Yes
13.	Has the child received vaccinations in the past 4 weeks?	No	Yes
14.	Has the child ever felt dizzy or faint before, during, or after a shot?	No	Yes
15.	Is the child anxious about getting a shot today?	No	Yes

FOR OFFICE USE ONLY

☐ No insurance/underinsured	☐ Merck Replacement	☐ Medicaid	☐ Medicare
☐ Private	☐ Self-Pay	☐ AVP	☐ VFC