LENAWEE COUNTY
HEALTH DEPARTMENT

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

Today's Date: _____ 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

INSURANCE INFORMATION		
SUBSCRIBER NAME	SUBSCRIBER DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURANCE COMPANY NAME	POLICY NUMBER	GROUP/PLAN NUMBER

SCREENING QUESTIONS			
1.	Is the Client sick today?	No	Yes
2.	Does the client have any allergies to food, medications or vaccines (if yes, what)	No	Yes
3.	If the child's age is between birth and eight months, have you ever been told he or she has had intussusception?	No	Yes
4.	Has the client ever had the chicken pox (Varicella) disease? (date)	No	Yes
5.	Adult clients only: when was your last Tetanus vaccinations (date)	No	Yes
6.	Does the client have a health problem with asthma, wheezing, lung disease, heart disease, kidney disease, a metabolic disease like diabetes, a blood disorder, or on long term aspirin therapy?	No	Yes
7.	Does the client smoke?	No	Yes
8.	Has the client ever had positive results from a TB skin test or been treated for Tuberculosis?	No	Yes
9.	Has the client had a serious reaction to a vaccine in the past?	No	Yes
10.	Has the client/ family member had a seizure, brain or other nervous system problem?	No	Yes
11.	Does the client have cancer, leukemia, AIDS, or any other immune system problem?	No	Yes
12.	In the past 3 months has client taken cortisone, prednisone, other steroids, anticancer drugs, or had radiation treatments?	No	Yes
13.	During the past year has client received a transfusion of blood or blood products, or been given a medicine call immune (gamma) globulin or an antiviral drug?	No	Yes
14.	Is female client pregnant, breastfeeding or could she become pregnant during the next month?	No	Yes
15.	In the past 4 weeks has the client received any vaccinations?	No	Yes

FOR OFFICE USE ONLY

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