LENAWEE COUNTY
HEALTH DEPARTMENT

Pediatric Immunizations

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

Today's Date: _____ Private Physician's Name: _____

Name: _____ Phone: _____

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 child sick today?	YES	NO
2.	Does the child have any allergies to medications, eggs, latex, Mercury, Thimerosal, or any vaccine? If **YES**, list:	YES	NO
3.	Has the child had a **SERIOUS REACTION** to a vaccine in the past?	YES	NO
4.	Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder, or are on long-term aspirin therapy?	YES	NO
5.	For children 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	YES	NO
6.	For babies, has a healthcare provider ever told you that the child has had intussusception?	YES	NO
7.	Has the child, a sibling, or a parent had a seizure or has the child had a brain or other nervous system problems?	YES	NO
8.	Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	YES	NO
9.	In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	YES	NO
10.	In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or antiviral drug?	YES	NO
11.	Is the child/teen pregnant or is there a chance they could become pregnant during the next month?	YES	NO
12.	Has the child received vaccinations in the past 4 weeks?	YES	NO

FOR OFFICE USE ONLY

VFC/EXPANDED ELIGIBILITY SCREENING STATEMENT
(the person receiving these immunizations is:)

☐ no insurance/underinsured	☐ is enrolled in MEDICAID	☐ *is covered by PRIVATE insurance (other than Medicaid) that covers all or part of the cost of immunizations*