UNLV
UNIVERSITY OF NEVADA LAS VEGAS
Student Health Center

Immunization Screening Questionnaire

Last Name	First Name	M. I.	Date of Birth	Student ID No. (NSHE#)

○ **Enrolled in Medicaid** ○ **American Indian/Alaskan Native** ○ **Underinsured** ○ **Insured** ○ **None**

Answer the following general medical questions. If you answer "**YES**" to any of the questions, the SHC nurse will evaluate you for a more detailed assessment.

YES	NO	
○	○	**1.** Have you been sick or had a fever over 100º within the last 24 hours?
○	○	**2**. Are you taking Cortisone, Prednisone or other steroids, x-ray treatment, Warfarin, anticoagulant or anticancer drug?
○	○	**3.** Have you been diagnosed with cancer, leukemia, AIDS or other disease causing immune system problems or any neurological disorder, or were you born with immune system problems? **Specify**:_____
○	○	**4.** Are you allergic to the preservative in vaccine called Thimerosal, which is so bad it needs medical care?
○	○	**5.** Are you allergic to any medication? **If yes, specify**:_____
○	○	**6.** Are you taking any medication? **If yes, specify**:_____
○	○	**7**. Are you allergic to Pertussis which is so bad it needs medical care?
○	○	**8**. Do you have any chronic illness (es)? **If yes, specify**:_____
○	○	**9**. Have you ever had an adverse or hypersensitivity reaction to any vaccine in the past?
○	○	**10. WOMEN ONLY:** Are you pregnant now or likely that you will become pregnant in the next 3 months?

***Select which vaccine(s) you are receiving today**

○**MMR** ○**Td** ○ **Tdap** ○ **Influenza (Flu)** ○**Hep A** ○**Hep B** ○**Hep A&B** ○**Meningococcal (MCV4)**

		YES	NO
I	**MEASLES MUMPS AND RUBELLA (MMR)**		
	1. Are you allergic to Neomycin, which is so bad it needs medical treatment?	○	○
	2. Are you allergic to eggs, which is so bad it needs medical treatment?	○	○
	3. Are you allergic to Phosphate?	○	○
	4. Are you allergic to Glutamate?	○	○
	5. Have you had a gamma globulin shot or a blood transfusion in the past 3 months?	○	○
II	**TETANUS, DIPHTHERIA, PERTUSSIS (Td) / (Tdap)**	○	○
	1. Are you allergic to Pertussis, Aluminum Potassium Sulfate, Sodium Phosphate or latex?	○	○
	2. Do you have a history of Guillain-Barre or encephalopathy?	○	○
	3. Has your last Td vaccine been longer than 2 years?	○	○
	4. Have you ever had a Tdap booster?	○	○
	5. Have you ever had a life threatening reaction to DTP, DTaP, DT, Td, i.e. coma or long seizure up to 7 days after vaccine?	○	○
	6. Do you have contact with newborns less than one year of age?	○	○
III	**INFLUENZA (Flu)**		
	1. Are you allergic to eggs, which is so bad it needs medical treatment?	○	○
IV	**HEPATITIS A**		
	1. Are you allergic to 2-Phenoxyethanol or Aluminum Hydroxide?	○	○
V	**HEPATITIS B**		
	1. Are you allergic or hypersensitive to yeast or Aluminum Hydroxide?	○	○
VI	**HEPATITIS A & B**	○	○
	1. Are you allergic to 2-Phenoxyethanol?	○	○
	2. Are you allergic or hypersensitive to yeast?	○	○
	3. Are you allergic to eggs, which is so bad it needs medical treatment?	○	○
	4. Are you allergic to Aluminum Hydroxide?	○	○
	5. Are you allergic to Phosphate?	○	○
	6. Are you allergic to **Neomycin**?	○	○
VII	**MENINGOCOCCAL**		
	1. Have you ever had Guillain-Barre syndrome?	○	○

_____ **I will remain in the Student Health Center for 15 minutes following my vaccination (s) for observation in the event of an adverse reaction.**
Initials

****WOMEN ONLY- We strongly recommend that you DO NOT get pregnant for at least 3 months after receiving any of the above vaccines***

CONSENT TO RECEIVE VACCINE (S)

I have received a copy of the vaccine information sheet (VIS) and I have read or have had a SHC clinical staff member explain to me the information about the vaccine receiving today. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and the risks of the vaccine(s). I request this vaccine be given to me or to the person named above for whom I am authorized to make this request.

Patient Signature:_____ **Date**_____

If Patient is a Minor (17 years old or younger)

Signature of Patients Parent or Representative:_____

Description of Legal Guardianship: _____ **Phone No.** _____