UNLV

Immunization Screening Questionnaire

AGE: _____

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 ever had an adverse reaction or hypersensitivity to any vaccine in the past?
○	○	**2**. Have you been sick or had a fever over 100º within the last 24 hours?
○	○	**3**. Are you taking Cortisone, Prednisone or other steroids, x-ray treatment, warfarin, anticoagulant or anticancer drug?
○	○	**4.** 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**:_____
○	○	**5.** Are you allergic to the preservative in vaccine called thimerosal, which is so bad it needs medical care?
○	○	**6.** Are you allergic to any medication? **If yes, specify**:_____
○	○	**7.** Are you taking any medication? **If yes, specify**:_____
○	○	**8.** Do you have any chronic illness (es)? **If yes, specify**:_____
○	○	**9**. Have you ever fainted after any injection or procedure requiring the use of a needle?
○	○	**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 ○ HepA&B ○ Meningococcal ○Pneumococcal

I MEASLES MUMPS AND RUBELLA (MMR)

	YES	NO
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 or Glutamate?	○	○
4. 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, and 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 (HAV)

1. Are you allergic or hypersensitive to 2-phenoxyethanol or aluminum hydroxide?	○	○

V HEPATITIS B (HBV)

1. Are you allergic or hypersensitive to yeast or aluminum hydroxide?	○	○

VI HEPATITIS A & B

1. Are you allergic or hypersensitive to 2-phenoxyethanol, phosphate or aluminum hydroxide?	○	○
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 **Neomycin**?	○	○

VII MENINGOCOCCAL (Meningitis A,C,W,Y or Meningitis B)

1. Have you ever had Guillain-Barre Syndrome?	○	○

VIII PNEUMOCOCCAL (Prevnar-13 or Pneumovax-23)

1. Are you allergic to bovine protein or phenol?	○	○

_____ 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

_____ I request a copy of the immunization record for the vaccine(s) I am receiving today. I authorize the release of my immunization record to myself; with the understanding it may include my complete immunization history at the Student Wellness Center.

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(s) being received 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 Legal Representative

Description of Legal Guardianship: _

Phone No.