Missoula Public Health
City-County Health Department

Missoula City-County Health Department
HEALTH SERVICES
301 West Alder Street | Missoula MT 59802-4123
www.missoulacounty.us/HealthDept
Phone | 406.258.4750
406.258.4745
Fax | 406.258.4913

Vaccine Screening Checklist

For Immunizations only: Please read carefully and check YES or NO.

The nurse will discuss any YES responses with you.

Please answer the following questions for the person receiving immunizations:

1. Is the client sick today? ☐ No ☐ Yes (please describe):

2. Please list any allergies and the type of reaction: ☐ **No known allergies**
☐ Baker's/Brewer's Yeast ☐ Casein/severe milk allergy ☐ Eggs ☐ Gelatin ☐ Latex ☐ Neomycin ☐ Streptomycin
☐ Thimerosal ☐ Other (describe): Type of reaction:

3. Has the client had a serious reaction after receiving a vaccination? ☐ No ☐ Yes (please describe):

4. Has the client had any vaccines in the last 4 weeks? ☐ No ☐ Yes (please describe):

5. Does the client have any of the following health problems: ☐ **None**
☐ anemia or other blood disorder ☐ asplenia (no spleen) ☐ asthma ☐ cerebrospinal fluid leak ☐ cochlear implant
☐ diabetes ☐ encephalitis ☐ Guillain-Barre syndrome ☐ heart disease ☐ liver disease (ex: cirrhosis, hepatitis)
☐ lung disease ☐ metabolic disease ☐ renal failure/dialysis ☐ seizures
☐ other health condition (please describe):

6. Does the client or close family member have any immune system problems: ☐ **No**
☐ cancer ☐ HIV/AIDS ☐ leukemia ☐ organ or stem cell transplant
☐ other immune system problem (please describe):

7. Is the client currently on long-term aspirin therapy?
☐ No ☐ Yes (please describe):

8. Does the client smoke cigarettes? ☐ **No** ☐ Yes

9. **In the past 3 months**, has the Client: ☐ **No**
☐ Had treatment with anticancer drugs ☐ Had radiation treatment
☐ Taken medications that can weaken the immune system such as steroids (ex: Prednisone) or biologics (ex: Enbrel, Humira) for the treatment of certain conditions like rheumatoid arthritis, Crohn's disease or psoriasis

10. **In the past year**, has the Client: ☐ **No**
☐ Received a transfusion of blood or blood products ☐ Received immune (gamma) globulin
☐ Taken an anti-viral drug (such as Acyclovir, Famciclovir, Valacyclovir)

11. **For females only:** Are you pregnant or breastfeeding or is there a chance you may become pregnant within a month?
☐ No ☐ Yes (please describe):

12. **For children 0-18 year only:** Has the child or a close family member ever had brain or other nervous system problem such as seizures or swelling of the brain? ☐ No ☐ Yes (please describe):

13. **For infants only:** Have you ever been told that your baby has had problems with their bowels (such as intussusception)?
☐ No ☐ Yes (please describe):

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Tuberculosis Screening Checklist

For TB Testing only: Please read carefully and check YES or NO.
The nurse will discuss any YES responses with you.

Tuberculosis Testing Only:	Yes	No
1. Reason for test: ☐ employment ☐ volunteer ☐ school ☐ overseas travel ☐ immigration ☐ foreign born ☐ exposure/contact ☐ other:		
2. Have you ever had a positive TB test result in the past?	☐	☐
3. Have you had any live virus vaccines in the past 4 weeks (such as MMR, Varicella, Yellow Fever, Zostavax)?	☐	☐
4. Are you currently sick or recently had a bacterial or viral infection?	☐	☐
5. Have you ever been in contact with anyone with active TB disease?	☐	☐
6. Have you ever had BCG? If yes, when:	☐	☐
7. Do you have any illness that may suppress your immune system, or are you on any immunosuppressive medications?	☐	☐
8. Are you able to return to the clinic in 3 days to get your test read? If you miss your return day, you will have to have a new test done and pay a new fee.	☐	☐

The clinic RN will review this section with you:

Safety Acknowledgement and Waiver:

1. ☐ **VIS:** I have read or have had explained to me the information contained in the Vaccine Information Statement(s) about the disease(s) and the vaccine(s).
   ☐ **N/A:** I am not receiving vaccines today.

2. ☐ **Authorization:** I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s), blood draw, TB test or other screening and request the vaccine(s), blood draw, TB test or other screening to be administered today to me or to the person named above for whom I am authorized to make this request.

3. I understand it is the policy of Missoula City-County Health Department's Immunization Clinic and International Travel Clinic to recommend that all individuals who have received an injection, blood draw, or TB test remain in the reception area for at least 15 minutes after their procedure. This is a safety precaution to avoid possible problems associated with fainting or an allergic reaction:
   ☐ **I AGREE to wait 15 minutes** ☐ **I DECLINE to wait 15 minutes**

Client (Parent/Guardian) Signature: _____ **Date:** _____
By signing this form, I agree that the information I provided is accurate and truthful and I agree with the acknowledgement and consent above.

RN Signature: _____ **Date:** _____