Student Name _____ Date of Birth _____

*This information is confidential and will be used for vaccination screening purposes only*

## SCREENING QUESTIONAIRE FOR CHILD AND TEEN Tdap IMMUNIZATION AT SCHOOL

**For Parents/Guardians**: The questions on this page have 2 purposes:

1. Determine if there is any reason your child should not receive the whooping cough (Tdap) booster vaccine.
2. Determine if your child qualifies to receive the vaccine through the VFC program. **Only children that qualify will be able to receive the vaccine given at school.**

**Please answer the questions, sign the form, and return them to your child's school with a copy of your child's immunization record.**

| **Answer all of the following questions with yes, no or don't know.** | **YES** | **NO** | **DON'T KNOW** |
|---|---|---|---|
| 1. Is your child sick todayl? | | | |
| 2. Does your child have a serious allergy to latex, medication or food? If yes, what? | | | |
| 3. Has your child had a serious reaction to a vaccine in the past? | | | |
| 4. Has your child had a seizure or disease affecting the brain? | | | |
| 5. Does your child have cancer, leukemia, AIDS, or any other immune system problem? | | | |
| 6. In the past 3 months, has your child taken cortisone, prednisone, other steroids, anticancer drugs, or radiation treatments? | | | |
| 7. In the past year, has your child received a transfusion of blood products or been given immune (gamma) globulin or an antiviral drug? | | | |

1. What health insurance does your child have? _____
   - ☐ My child does not have health insurance
   - ☐ My child has Medi-Cal
2. My child is Native American/Native Alaskan ☐ Yes ☐ No
3. Mother's first name_____

**I have read the Tdap Immunization Statement and request that my child receive the vaccine.**

_____ _____

Parent/Guardian Signature Date

FOR CLINIC USE ONLY

Form reviewed by _____

Qualifies for VFC ☐ Yes ☐ No

Shot given by _____ Date _____

Left Right Manufacturer Lot # Exp. Date