

Patient name: Shay HollingsworthDate of birth: 10/19/01
(mo.) (day) (yr.)

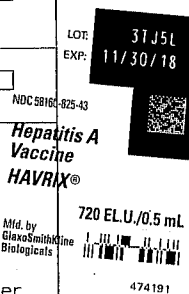
Screening Checklist for Contraindications to Vaccines for Children and Teens

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Is the child sick today?	☐	☒	☐
2. Does the child have allergies to medications, food, a vaccine component, or latex?	☐	☒	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☒	☐
4. Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	☐	☒	☐
5. If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐	☒	☐
6. If your child is a baby, have you ever been told he or she has had intussusception?	☐	☒	☐
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐	☒	☐
8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☒	☐
9. In the past 3 months, has the child taken medications that weaken their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?	☐	☒	☐
10. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☒	☐
11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☒	☐
12. Has the child received vaccinations in the past 4 weeks?	☐	☒	☐

Form completed by: S. Hollingsworth
Form reviewed by: [Signature]Date: 6-12-17
Date: 6/12/17**Did you bring your child's immunization record card with you?**yes ☒ no ☐

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.

2 arm

AUM STUDENT HEALTH CENTER
TRAVEL HEALTH HISTORY

Date 6-12-17 Name Shay Hollingsworth

1. What is the reason for your visit today Typhoid & Hep-a Shots
2. List allergies you have to medicines, foods or iodine: none
3. List any medications or drugs you are currently taking (this would include herbal and over-the-counter as well as prescription drugs): none

4. Have you had any of the following: (circle if this applies to you);

Heart disease _____

Kidney disease _____

Stomach/Gastrointestinal disease _____

Diabetes/sugar _____

5. Are you immunocompromised? (Is there a problem with your immune system) Yes _____ No ☒

Thymus disorder (Myasthenia gravis, thymoma, thymectomy) _____

Spleen removed _____

Transplant recipient _____

Cirrhosis of the liver _____

Cancer _____

HIV _____

6. How often do you drink beer, wine, wine cooler, or liquor? (Please circle)
Never / Rarely / 1-2 times a week / 3-4 times a week / 5 or more times a week

7. Where are you going on your trip? Haiti

8. How long is your trip? Months _____ Days 0

9. When are you leaving on your trip? June 16th 2017

FOR FEMALES ONLY

- A. Date of your last period? 6/1/17 Have you had a hysterectomy? YES _____ NO ☒

- B. Are you currently pregnant? YES _____ NO ☒

What is your due date? _____

- C. Do you plan to become pregnant in the next 3 months? YES _____ NO ☒

- D. Are you breastfeeding? YES _____ NO ☒