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Pre-Vaccination Screening

Has the patient experienced fever, diarrhea or vomiting in the last 24 hours? Yes No

Please explain: _____

Does the patient have allergies to eggs, yeast, gelatin, thimerasol, medications, or vaccines? Yes No

If so, what are the allergies? _____

Does the patient have difficulty fighting infections? Yes No

If yes, please explain: _____

Has the patient ever been diagnosed with a bleeding disorder? Yes No

Has the patient...

Ever experienced a reaction to vaccine such as fainting, hives, breathing problems, prolonged high-pitched cry? Yes No

Ever experienced seizures or convulsions? Yes No

Received any blood products during the past six months? Yes No

Taken medications that may cause excessive bleeding? Yes No

Recently taken or been prescribed steroids? Yes No

Is the patient pregnant or planning to become within the next four weeks? Yes No

Signed

Date