Azusa Pacific University Health Center
Vaccine Screening Questions

The following questions should be answered before completing the immunization process. Please mark your answer yes or no for each question.

1. Are you sick today or do you have a fever? Yes__ No__
2. Did you ever have a reaction or high fever to an immunization which was so bad you had to go to the doctor or hospital? Yes__ No__
3. Are you or anyone in your home/living area taking cortisone, prednisone, other steroids or x-ray treatments. Yes__ No__
4. Do you or anyone in your home/living area have cancer, leukemia, AIDS or other immune system problems? Yes__ No__
5. Do you have neurologic problems affecting the brain or nerves? Yes__ No__
6. Do you or a brother, sister, or parent have a history of seizures? Yes__ No__
   If yes, date of last seizure__________________________
7. Do you have an allergy to eggs, to neomycin, streptomycin, baker's yeast, gelatin, thimerosal, or polymyxin B which is so severe that it needs medical treatment? Yes__ No__
8. Have you ever had a problem with a bleeding disorder or easy bruising? Yes__ No__
9. Have you had a blood transfusion or immune globulin in the past year? Yes__ No__
   If so, when?____
10. Female Adolescents/Adults requesting immunization: Date of LMP:____________
    Are you pregnant now or intend to become pregnant within the next three months? Yes__ No__
11. Have you read the information sheet about the vaccine you are receiving? Yes__ No__

Vaccine to be given: MMR __TD__ Hep B# __ Hep A# __Twinrix #___ Flu __Other___

Information about person to receive vaccine (Please print)			
Name: Last First Middle Initial		Birthdate	Age
Address: Street City		State	Zip
Signature of person to receive vaccine or person authorized to make the request (guardian): **X** Date			
ID# 000-	Phone# ( )	Box#	

APU Health Center staff will record any/all immunizations given in the Health Center on the APU Immunization Flow Sheet.

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