

## Pre Vaccination Checklist

Student's name: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth: ____/____/____ mm dd yy
School: _____	Grade: _____	Class: _____

To ensure safe vaccination, the nurse requires information about your child. Please review and complete the following checklist. The nurse must receive the completed checklist prior to vaccinating your child.

For further information, please contact the school nurse on phone No.: .....

Please note: Answering Yes to any question(s) does not necessarily mean that the student can't be vaccinated at the school clinic.

#	Category	Yes	No
1	Does the student have any health condition that weakens the immune system such as Leukemia, Lymphoma, Organ Transplant or AIDS?		
2	Did the student receive gamma globulin, blood or plasma in the last three months?		
3	Has the student had any previous reaction to any vaccine? If yes please list it: .....		
4	Is the student allergic to yeast, neomycin, gelatin, eggs or mercury? Please list allergies _____		
5	Has the student had Eczema or Dermatitis or a history of these conditions?		
6	Does the student have any bleeding disorder or is he/ she taking any anti-coagulant (blood thinning) medicine?		
7	Has the student had any other vaccine in the past month? If yes; please name the vaccine taken.-----		
8	Has the student had chicken-pox? If yes please send medical report confirming that.		
9	Has the student had previously vaccinated against chicken-pox? <b>If yes, please send his/her vaccination document confirming that.</b>		
10	Are there any other health related problems? E.g: asthma, epilepsy, upper respiratory tract infection, gastroenteritis.... Specify _____		
11	Does the student take hydrocortisone or any medication contains corticosteroids?		
12	Female student (Grade 11): is the student planning for marriage and pregnancy in the next three months?		
13	Do you have any questions regarding the vaccine, please mention them?		

**Note:** Attach medical report, if vaccine is contraindicated.

Inform the school nurse about any changes regarding student's health during vaccines time:

Name of Parent/ Guardian:..... Contact number:.....

Parent/ Guardian Signature: ..... Date: .....