Truman State University Student Health Center

Meningitis Vaccine Screening Questionnaire and Administration Record

Name_____ Date_____

Banner ID_____ Birthday_____ Age_____

College Address_____ College Phone_____

Year in School (please circle one) ☐ FR ☐ SO ☐ JR ☐ SR ☐ GRAD

Please answer the following questions by checking the appropriate box:	**Yes**	**No**	**Unsure**
1. Have you ever received a meningococcal vaccine?	☐	☐	☐
2. Are you sick today?	☐	☐	☐
3. Are you currently taking any medications other than birth control?	☐	☐	☐
4. Have you ever had a reaction to a vaccine?	☐	☐	☐
5. Do you have any drug allergies?	☐	☐	☐
6. Have you ever been diagnosed with a bleeding disorder?	☐	☐	☐
7. Do you have any chronic illnesses?	☐	☐	☐
8. Do you have an immune deficiency?	☐	☐	☐
9. For women only: Are you pregnant or is there a possibility that you could be pregnant?	☐	☐	☐
10. During the past year, have you received any blood transfusions or blood products, or taken a medication called immune (gamma) globulin?	☐	☐	☐
11. Have you received any vaccinations in the past four weeks?	☐	☐	☐
12. Do you take any steroids, anticancer drugs, or any immune suppressing treatments?	☐	☐	☐

Vaccine: Meningococcal Vaccine

Date Administered: _____

Type of Vaccine: _____

Vaccine Information Statement (VIS): _____ Staff Use Only

Manufacturer: _____

Lot Number: _____ **Expiration Date**: _____

Injection Site (SQ): RA LA **or** (IM-Deltoid): RA LA

Signature of Provider: _____

Revised 08-2007 CD