TEXAS DEPARTMENT OF HEALTH
ADOLESCENT INITIAL HISTORY FORM
(11-21 YEARS)

Today's Date: _____

NAME: _____
DOB: ___/___/___ SEX: ____
SSN/RECORD #: _____
RACE/ETHNICITY: _____
Medical Home: _____
Insurance: _____

**Please answer all questions on this form in reference to the teenage patient.

- Home phone #: _____ Work Phone # _____
- Permanent Contact Name: _____ Relationship: _____ Phone #: _____
- If needed, can we call your home & leave message for you saying "the clinic called? ☐ Yes ☐ No
- Who brought you to clinic today? _____
- Are you in school? ☐ Yes ☐ No Name: _____ Grade _____
- Do you have a job? If so, where do you work? _____

Medical History:

1. Do you have any health problems? ☐ Yes ☐ No
Problems: _____

2. Have you ever been hospitalized for an illness or had an operation? ☐ Yes ☐ No
If yes, give age and explain the reason for hospitalization or operation:
Age _____ Reason: _____
Age _____ Reason: _____
Age _____ Reason: _____

3. Have you had any serious injuries? ☐ Yes ☐ No
If yes, give age and describe the injury:
Age _____ Injury: _____
Age _____ Injury: _____

4. Do you take any medications regularly? ☐ Yes ☐ No

Medication	How long	Reason

5. Do you have any allergies to medicines? ☐ Yes ☐ No
Name of medicine: _____ Type of reaction: _____
Name of medicine: _____ Type of reaction: _____

6. If you ever had any of the following problems, please write how old you were when it started:

	Yes	No	Age
Acne	☐	☐	____
Asthma	☐	☐	____
Bladder infection	☐	☐	____
Tuberculosis	☐	☐	____
Chicken pox	☐	☐	____
Mononucleosis	☐	☐	____
Hepatitis	☐	☐	____
STD's	☐	☐	____
Headaches	☐	☐	____
Seizures/epilepsy	☐	☐	____
Vision	☐	☐	____
Hearing problems	☐	☐	____
Depression	☐	☐	____
Emotional problems	☐	☐	____
Learning problems	☐	☐	____
Sickle cell anemia or trait	☐	☐	____
Stomach ulcer	☐	☐	____
Heart disease	☐	☐	____
Diabetes	☐	☐	____
Thyroid	☐	☐	____
Cancer	☐	☐	____
Scoliosis/back problems	☐	☐	____
Other: _____	☐	☐	____
Other: _____	☐	☐	____

Name: _____ Date of Birth: _____ Today's Date: _____

7. Specific Health Concerns:

Please check below if you have any questions or concerns about any of the following:

- ☐ Height
- ☐ Blood pressure
- ☐ Acne
- ☐ Breasts
- ☐ Heart
- ☐ Appetite
- ☐ Stomach pain
- ☐ Nausea/vomiting
- ☐ Diarrhea/constipation
- ☐ Chest pain
- ☐ Coughing/wheezing
- ☐ Wetting the bed
- ☐ Frequent or painful urination
- ☐ Headaches
- ☐ Trouble sleeping
- ☐ Tiredness
- ☐ Vision problems
- ☐ Hearing problems
- ☐ Learning or school problems
- ☐ Muscle or joint pain
- ☐ Cancer
- ☐ Dying
- ☐ Menstruation/periods
- ☐ Pregnancy
- ☐ Sexual organs/genitals
- ☐ Physical or sexual abuse
- ☐ Other: _____

8. Family Information:

Please check if anyone in your family (including grandparents, aunts, uncles, cousins, etc.) Have or had any of the following problems:

Yes	No		Relationship
☐	☐	Cancer	_____
☐	☐	Heart attack (<55 yrs)	_____
☐	☐	High blood pressure	_____
☐	☐	Diabetes	_____
☐	☐	Alcoholic	_____

Yes	No		Relationship
☐	☐	Drug abuse	_____
☐	☐	Mental illness	_____
☐	☐	Learning problems	_____
☐	☐	Tuberculosis	_____
☐	☐	Stroke	_____

9. With whom do you live? _____

Do you have any family problems? ☐ Yes ☐ No

If yes, explain: _____

10. During the past year have there been any of the following changes in your family:

☐ Marriage ☐ Serious illness ☐ Births ☐ Deaths

☐ Separation ☐ Divorce ☐ Loss of job ☐ Other: _____

11. Patient's father/guardian's job: _____ **Patient's mother/guardian's job:** _____

12. Have you ever lived away from home? ☐ Yes ☐ No

If yes, explain: _____

13. Form filled out by: ☐ patient ☐ guardian/parent ☐ other: _____

Date: _____ Nurse's signature: _____

Date: _____ Provider's signature: _____

Form developed by The Center for Adolescent Health at People's Community Clinic and The Austin Pediatric Education Program. Adapted from GAPS.

TEXAS DEPARTMENT OF HEALTH
ADOLESCENT HEALTH RECORD
ANNUAL HEALTH VISIT (11-21 YRS)

NAME: _____
DOB: ___/___/___ SEX: ____
SSN/RECORD #: _____
RACE/ETHNICITY: _____
Medical Home: _____
Insurance: _____

Home phone #: _____ Alternate phone # _____ Can we call & leave message? ☐ Yes ☐ No
Today's Date: _____ Brought by: _____ Consent signed? ☐ Yes ☐ No

Past Medical History: Review initial history form and note any interim changes below:

☐ No changes in chronic problems or previous medical history

☐ **Changes** (in previous medical history, hospitalizations, chronic problems):

Developmental Delays/ Disabilities (please explain fully):

Current Concerns:
Adolescent: _____
Parent/Guardian: _____

Review of Systems: (If negative, check the box "☐ neg" to the right of each item below)

- **Eyes** (last eye exam, blurred vision, etc.) _____ ☐neg
- **Ears** (ringing in ears, hearing problems, pain) _____ ☐neg
- **Dental** (bleeding, pain, cavities) _____ ☐neg Last dental exam: _____
- **Pulmonary** (wheezing, breathing problems, etc.) _____ ☐neg
- **Cardio** (chest pain, exercise intolerance, etc.) _____ ☐neg
- **GI** (vomiting, diarrhea, constipation, wt loss/gain, etc.) _____ ☐neg
- **GU** (enuresis, vaginal/penile discharge, etc.) _____ ☐neg
- **Skeletal** (bone or joint problems) _____ ☐neg
- **Menses** _____ (age onset) x _____ (length of cycle) x _____ (# days flow), LMP _____
- **Dysmenorrhea ?** _____ ☐neg
- **Sexually active?** (In the past or currently): ☐yes ☐no # partners in past: _____ ☐none
  Age at 1st intercourse: _____ Past STD's _____ ☐neg
- **Last pap smear date** _____ # of pregnancies or fathering ofchildren: _____ ☐none
- **Birth control use** ☐sometimes ☐never ☐ always Method used: _____ ☐none
- **Neuro** (headaches, coordination problems, etc.) _____ ☐neg
- **Other** _____ ☐neg

☐ No recent / current meds ☐ Recent / current / regular **meds:**	☐ No drug allergies ☐ Drug **Allergies:**	☐ no changes in family history since last visit ☐ Changes in **family history:**

The information on the following page is outlined in the ***HEADS*** format (actually, ***HEEADDSS***). Words in parentheses are examples of topics to ask about, but are by no means comprehensive! (See Scripts for details) **Keep in the mind the developmental stage of the adolescent while asking about some of the topics.

Name: DOB: Date:

* Interviewed patient alone ☐yes ☐no * Interviewed adult alone ☐yes ☐no

HOME: (other individuals living at home, family stressors, ever stays at home alone, financial support, type of housing, etc.)
Per accompanying adult:

Per patient:

EDUCATION: (name of school, grade, avg. grades, difficulties in classes, special ed classes, plans after high school, etc.)
Per accompanying adult:

Per patient:

EATING: (perception of body, typical diet, hx of fad diets, vitamin supplements used, access to 3 meals/day, etc.)
Per accompanying adult:

Per patient:

(For further nutritional evaluation, refer to form CH-15)

ACTIVITIES: (sports, hobbies, hrs of TV/video games per day, jobs, gang-related activities, legal trouble, etc.)
Per accompanying adult:

Per patient:

DEPRESSION: (general mood, suicide attempts by self, friends or family, sleep problems, self esteem, etc.)
Per accompanying adult:

Per patient:

DRUGS: (type & freq of drug & alcohol use, IV drug abuse, smoking, drunk driving, riding w/drunk driver, etc.)
Per accompanying adult:

Per patient:

SAFETY: (use of seat belt, use of protective gear in sports, perceived safety, access to/handling of weapons, etc.)
Per accompanying adult:

Per patient:

SEXUAL ACTIVITY: (sexual orientation, history of sexual or physical abuse, amount of sexual education, etc.)
Per accompanying adult:

Per patient:

TEXAS DEPARTMENT OF HEALTH
ADOLESCENT HEALTH RECORD
ANNUAL HEALTH VISIT (11-21 YRS)

NAME: _____
DOB: ____/____/____ SEX: _____
SSN/RECORD #: _____
RACE/ETHNICITY: _____
Medical Home: _____
Insurance: _____

PURE TONE AUDIOMETRIC SCREENING (Screen frequencies at 25 dB)			
Ear	1000 Hz	2000 Hz	4000 Hz
Right			
Left			

Tuberculosis questionnaire: ☐ Pass ☐ Fail ☐ Not done
Pure tone hearing screen above: ☐ Pass ☐ Fail ☐ Not done
Vision Screening: ☐ Right 20/____ ☐ Left 20/____ ☐ Not done

PHYSICAL EXAM:

Ht: ____in ____% Wt: ____ lb____% BMI: (see tables)____ Temp: ____ Blood pressure: ____/____

N	A	NE	Normal findings -	Explain significant and abnormal findings
			General (well developed, alert and oriented x 3) Affect: (good eye contact, normal affect)	
			Skin (no acne or rashes)	
			Eyes (PERRL, EOMI)	
			Ears (TM's: clear, mobile) Nose (no septal deviation or obstruction)	
			Oropharynx (moist, no exudate)	
			Teeth (no cavities, good alignment)	
			Neck (supple, no lymphadenopathy, thyroid not palpable)	
			Breasts (symmetric, no masses, no gynecomastia) (Tanner 1 2 3 4 5) ☐ Reviewed self breast exam	
			Lungs (clear and equal breath sounds)	
			CV (RRR, no murmur, nl S1, S2, quiet precordium, pulses nl)	
			Abdomen (no masses, nontender, soft, no HSM, good BS)	
			Genitalia (Tanner 1 2 3 4 5), no hernia, nl external Testes descended bilat ☐ Reviewed self testicular exam	
			Pelvic (if medically indicated): nl external genitalia, cervix (no CMT, lesions, discharge) fundus and adnexae (not enlarged, not tender)	
			Back / Spine (no scoliosis)	
			Extremities (nl ROM all joints no deformities)	
			Neuro (DTR's 2 + bilat, nl strength, nl coordination& gait)	

Lab Results (document here only if results received today, for e.g. KPH, wet prep, spun Hct, UA, Urine B HCG, etc):

Name: DOB: Date:

PROBLEM LIST/ASSESSMENT:

PLAN:

- **Anticipatory Guidance/Health Education:** Document topics discussed on the preventative services master checklist.
- **Labs, immunizations and referrals*:**
  - ☐ Hct
  - ☐ Cholesterol
  - ☐ UA
  - ☐ Gen probe
  - ☐ Pap Smear
  - ☐ Wet prep
  - ☐ Other labs:
  - ☐ Varicella 1 2
  - ☐ Hep B 1 2 3
  - ☐ MMR 1 2
  - ☐ Td
  - ☐ PPD
  - ☐ STD
  - ☐ Dental referral
  - ☐ Vision screening referral
  - ☐ Counseled per family planning protocol
  - ☐ Other referrals:

*(Refer to recommendations on the master checklist for guidelines on screening for items listed above.)

- **Other plans:**

Next appointment: **Reason(s):**
Date: **Nurse:** **Resident/Provider:**
Attending Physician:

C.13 24-Hour Dietary Recall and Assessment for Children (10–20 Years) (2 Pages)

24-Hour Dietary Recall and Assessment for Ages 10 Through 20 Years (Nonpregnant)

Name _____
DOB _____ Age _____
SSN/Record No. _____
Required for Child / Teen Health

Medical Risks

*Is child or teen underweight or overweight, or does child or teen have poor growth? _____ ☐ Yes ☐ No
If yes, list: _____
*Does child or teen have anemia? _____ ☐ Yes ☐ No
*Does child or teen have lead poisoning? _____ ☐ Yes ☐ No
*Does child or teen have chronic vomiting, diarrhea, or constipation? _____ ☐ Yes ☐ No
If yes, list: _____

Resources

Working stove and refrigerator? _____ ☐ Yes ☐ No
☐ School breakfast ☐ Food Stamps
☐ School lunch ☐ Food pantry or soup kitchen
☐ Summer food program
Do you need help in obtaining food? _____ ☐ Yes ☐ No

Weight-Loss Practices

How do you feel about your weight? _____ ☐ Good ☐ Bad
*Any restrictive dieting practices? _____ ☐ Yes ☐ No
Check all that apply:
☐ Skipped meals ☐ Vomiting ☐ Excessive exercise
☐ Diet pills ☐ Laxatives
Diet supplements or fad diets? _____ ☐ Yes ☐ No
If yes, describe: _____
Do you feel your eating is out of control? _____ ☐ Yes ☐ No

Dietary Practices

*Any therapeutic/special diet? _____ ☐ Yes ☐ No
If yes, describe: _____ Prescribed by: _____
GI problems with milk products? _____ ☐ Yes ☐ No
*Any major food allergies? _____ ☐ Yes ☐ No
If yes, list: _____ Symptoms: _____
*Any food groups refused? _____ ☐ Yes ☐ No
If yes, list: _____
Do you eat or avoid any special foods for religious or health reasons? _____ ☐ Yes ☐ No
If yes, describe: _____

Health Habits

Hours of TV per day: _____
How many minutes per day are you physically active? _____
How many meals given daily? _____
Snacks eaten daily, including beverages such as sports drinks or sodas? _____ ☐ Yes ☐ No
If yes, list: _____
How many snacks per day? _____
"Fast food" eaten: _____
Alcohol/tobacco/street drugs? _____ ☐ Yes ☐ No
If yes, what kind? _____ How often? _____ How much? _____
Vitamin/mineral pills? _____ ☐ Yes ☐ No
If yes, list brand or type: ☐ Yes ☐ No

*If yes to any of these questions, complete a 24-hour dietary recall.

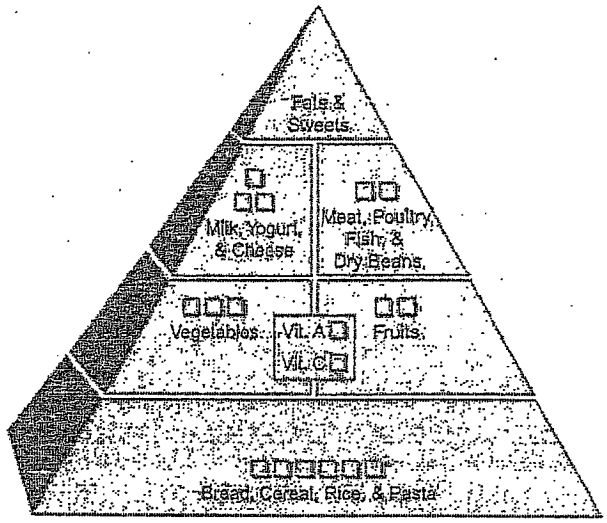
Recall taken by: _____
Recall assessed by: _____ Date: _____

ECH-15 Rev. 8/04 TEXAS

Counseled on

- ☐ healthy diet
- ☐ weight mangement / fad diets
- ☐ nutrition for sports
- ☐ eating regular meals 3x/day
- ☐ healthy snacks
- ☐ other: _____
- ☐ healthy "fast food" choices
- ☐ iron-rich foods
- ☐ calcium-rich foods
- ☐ physical activity
- ☐ inadequate/excessive intake of: _____
- ☐ smoking/alcohol/drugs
- ☐ GI disturbances or problems with milk
- ☐ low-fat eating for heart health
- ☐ physical activity

Date: _____ Counseled by: _____



Minimum Servings

List all foods and beverages consumed in the past 24 hours or previous day.	Amount Consumed

C.55 TB Questionnaire

Name of Child _____ Date of Birth _____

Organization administering questionnaire _____ Date _____

Tuberculosis (TB) is a disease caused by TB germs and is usually transmitted by an adult person with active TB lung disease. It is spread to another person by coughing or sneezing TB germs into the air. These germs may be breathed in by the child.

Adults who have active TB disease usually have many of the following symptoms: cough for more that two weeks duration, loss of appetite, weight loss of ten or more pounds over a short period of time, fever, chills and night sweats.

A person can have TB germs in his or her body but not have active TB disease (this is called latent TB infection or LTBI).

Tuberculosis is preventable and treatable. TB skin testing (often called the PPD or Mantoux test) is used to see if your child has been infected with TB germs. No vaccine is recommended for use in the United States to prevent tuberculosis. The skin test is not a vaccination against TB.

We need your help to find out if your child has been exposed to tuberculosis.

Place a mark in the appropriate box:	Yes	No	Don't Know
TB can cause fever of long duration, unexplained weight loss, a bad cough (lasting over two weeks), or coughing up blood. As far as you know: has your child been around anyone with any of these symptoms or problems? or has your child had any of these symptoms or problems? or has your child been around anyone sick with TB?			
Was your child born in Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia?			
Has your child traveled in the past year to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia for longer than 3 weeks? If so, specify which country/countries?			
To your knowledge, has your child spent time (longer than 3 weeks) with anyone who is/has been an intravenous (IV) drug user, HIV-infected, in jail or prison or recently came to the United States from another country?			

Has your child been tested for TB? Yes___ (if yes, specify date ___/___) No___

Has your child ever had a positive TB skin test? Yes___ (if yes, specify date ___/___) No___

For school/healthcare provider use only

****

PPD administered Yes___ No___

If yes,

Date administered ___/___/___ Date read ___/___/___ Result of PPD test _____ mm response

Type of service provider (i.e. school, Health Steps, other clinics) _____

PPD provider _____ _____

signature printed name

Provider phone number _____

City _____ County _____

If positive, referral to healthcare provider Yes___ No___

If yes, name of provider _____

Step

Patient name: _____ Date of birth: ____/____/____ (mo.) (day) (yr.)

Screening Questionnaire for Child and Teen Immunization

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 between the ages of 2 and 4 years, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐	☐	☐
6. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐	☐	☐
7. Does the child have cancer, leukemia, AIDS, or any other immune system problem?	☐	☐	☐
8. In the past 3 months, has the child taken cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?	☐	☐	☐
9. 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?	☐	☐	☐
10. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐	☐
11. Has the child received vaccinations in the past 4 weeks?	☐	☐	☐

Form completed by: _____ Date: _____

Form reviewed by: _____ Date: _____

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 a personal record, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep this record in a safe place and bring it with you every time you seek medical care for your child. Your child will need this important document for the rest of his or her life to enter day care or school, for employment, or for international travel.

Technical content reviewed by the Centers for Disease Control and Prevention, October 2011

www.immunize.org/catg.d/p4060.pdf • Item #P4060 (10/11)

Immunization Action Coalition • 1573 Selby Ave. • St. Paul, MN 55104 • (651) 647-9009 • www.immunize.org • www.vaccineinformation.org

Information for Health Professionals about the Screening Questionnaire for Child & Teen Immunization

Are you interested in knowing why we included a certain question on the Screening Questionnaire? If so, read the information below. If you want to find out even more, consult the references listed at the bottom of this page.

1. Is the child sick today? *[all vaccines]*
There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events (1, 2). However, as a precaution with moderate or severe acute illness, all vaccines should be delayed until the illness has improved. Mild illnesses (such as otitis media, upper respiratory infections, and diarrhea) are NOT contraindications to vaccination. Do not withhold vaccination if a person is taking antibiotics.

2. Does the child have allergies to medications, food, a vaccine component, or latex? *[all vaccines]*
If a person reports they have an allergy to egg, ask if they can eat lightly cooked eggs (e.g., scrambled eggs). If they can, trivalent influenza vaccine (TIV) may be admininistered. If after eating eggs or egg-containing foods, they have a reaction consisting of only hives, TIV may be given and the person should be observed for at least 30 minutes. If a person experiences a serious systemic or anaphylactic reaction (e.g., hives and either swelling of the lips or tongue, acute respiratory distress, or collapse) after eating eggs, do not administer TIV or live attenuated influenza vaccine (LAIV). It is possible that they may be eligible to be given TIV, but only after they have seen a physician with expertise in the management of allergic conditions. If a person has anaphylaxis after eating gelatin, do not administer measles-mumps-rubella (MMR), MMR+varicella (MMRV), or varicella vaccine. A local reaction is not a contraindication. For a table of vaccines supplied in vials or syringes that contain latex, go to www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/latex-table.pdf. For an extensive table of vaccine components, see reference 3.

3. Has the child had a serious reaction to a vaccine in the past?
[all vaccines] History of anaphylactic reaction (see question 2) to a previous dose of vaccine or vaccine component is a contraindication for subsequent doses (1). History of encephalopathy within 7 days following DTP/DTaP is a contraindication for further doses of pertussis-containing vaccine. Precautions to DTaP (not Tdap) include the following: (a) seizure within 3 days of a dose, (b) pale or limp episode or collapse within 48 hours of a dose, (c) continuous crying for 3 or more hours within 48 hours of a dose, and (d) fever of 105°F (40°C) within 48 hours of a previous dose. There are other adverse events that might have occurred following vaccination that constitute contraindications or precautions to future doses. Under normal circumstances, vaccines are deferred when a precaution is present. However, situations may arise when the benefit outweighs the risk (e.g., during a community pertussis outbreak).

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? *[LAIV]*
Children with any of the health conditions listed above should not be given the intranasal, live attenuated influenza vaccine (LAIV). These children should be vaccinated with the injectable influenza vaccine.

5. If the child to be vaccinated is between the ages of 2 and 4 years, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months? *[LAIV]*
Children who have had a wheezing episode within the past 12 months should not be given the live attenuated influenza vaccine. Instead, these children should be given the inactivated influenza vaccine.

6. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problem? *[DTaP, Td, Tdap, TIV, LAIV, MMRV]* DTaP and Tdap are contraindicated in children who have a history of encephalopathy within 7 days following DTP/DTaP. An unstable progressive neurologic problem is a precaution to the use of DTaP and Tdap, and a progressive neurologic disorder in a teen is a precaution to the use of Td. For children with stable neurologic disorders (including seizures) unrelated to vaccination, or for children with a family history of seizures, vaccinate as usual (*exception:* children with a personal or family [i.e., parent or sibling] history of seizures generally should not be vaccinated with MMRV; they should receive separate MMR and VAR vaccines). A history of Guillain-Barré syndrome (GBS) is a consideration with the following: 1) Td/Tdap: if GBS has occurred within 6 weeks of a tetanus-containing vaccine and decision is made to continue vaccination, give age-appropriate Tdap instead of Td if no history of prior Tdap; 2) Influenza vaccine (TIV or LAIV): if GBS has occurred within 6 weeks of a prior influenza vaccination, vaccinate with TIV if at high risk for severe influenza complications.

7. Does the child have cancer, leukemia, AIDS, or any other immune system problem? *[LAIV, MMR, MMRV, RV, VAR]*
Live virus vaccines (e.g., MMR, MMRV, varicella, rotavirus, and the intranasal live, attenuated influenza vaccine [LAIV]) are usually contraindicated in immunocompromised children. However, there are exceptions. For example, MMR is recommended for asymptomatic HIV-infected children who do not have evidence of severe immunosuppression. Likewise, varicella vaccine should be considered for HIV-infected children with age-specific CD4+ T-lymphocyte percentage at 15% or greater and may be considered for children age 8 years and older with CD4+ T-lymphocyte counts of greater than or equal to 200 cells/μL. Immunosuppressed children should not receive LAIV. Infants who have been diagnosed with severe combined immunodeficiency (SCID) should not be given a live virus vaccine, including rotavirus (RV) vaccine. For details, consult the ACIP recommendations (4, 5, 6).

8. In the past 3 months, has the child taken cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments? *[LAIV, MMR, MMRV, VAR]*
Live virus vaccines (e.g., MMR, MMRV, varicella, LAIV) should be postponed until after chemotherapy or long-term high-dose steroid therapy has ended. For details and length of time to postpone, consult the ACIP statement (1). To find specific vaccination schedules for stem cell transplant (bone marrow transplant) patients, see reference 7. LAIV can be given only to healthy non-pregnant individuals age 2–49 years.

9. 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? *[LAIV, MMR, MMRV, VAR]*
Certain live virus vaccines (e.g., LAIV, MMR, MMRV, varicella) may need to be deferred, depending on several variables. Consult the most current ACIP recommendations or the current *Red Book* for the most current information on intervals between antiviral drugs, immune globulin or blood product administration and live virus vaccines (1, 2).

10. Is the child/teen pregnant or is there a chance she could become pregnant during the next month? *[LAIV, MMR, MMRV, VAR]*
Live virus vaccines (e.g., MMR, MMRV, varicella, LAIV) are contraindicated one month before and during pregnancy because of the theoretical risk of virus transmission to the fetus (1, 6). Sexually active young women who receive a live virus vaccine should be instructed to practice careful contraception for one month following receipt of the vaccine (5, 8). On theoretical grounds, inactivated poliovirus vaccine should not be given during pregnancy; however, it may be given if risk of disease is imminent (e.g., travel to endemic areas) and immediate protection is needed. Use of Td or Tdap is not contraindicated in pregnancy. At the provider's discretion, either vaccine may be administered during the 2nd or 3rd trimester (9).

11. Has the child received vaccinations in the past 4 weeks?
[LAIV, MMR, MMRV, VAR, yellow fever]
If the child was given either live, attenuated influenza vaccine (LAIV) or an injectable live virus vaccine (e.g., MMR, MMRV, varicella, yellow fever) in the past 4 weeks, they should wait 28 days before receiving another vaccination of this type. Inactivated vaccines may be given at the same time or at any spacing interval.

References:
1. CDC. General recommendations on immunization, at www.cdc.gov/vaccines/pubs/acip-list.htm.
2. AAP. *Red Book: Report of the Committee on Infectious Diseases* at www.aapredbook.org.
3. Table of Vaccine Components: www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf.
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