

## BCG VACCINATION QUESTIONNAIRE

Please contact us before your appointment if:

- You answered one or more of the questions below with "Yes"
- Your child has fever (38.0°C or more) on the day of your appointment

<i>To be completed by parents/caregivers</i>				
Name child	:	.....		
Birthday of your child	:	.....		
Family doctor	:	.....		
Insurance + Policy nr.	:	.....		
Telephone	:	BSN:	.....	
		Yes	No	Unknown
<b>1. Was your child born outside of the Netherlands?</b>				
<b>2. Does your child use medicines?</b> If so, which?.....				
<b>3. Does your child have a skin disease?</b> If so, which?.....				
<b>4. Is your child being treated by a doctor in a hospital?</b> Is so, for what condition? ..... What is the name of the doctor who treats your child?.....				
<b>5. Was your child operated upon less than 1 week ago?</b>				
<b>6. Did your child travel abroad?</b> If so, to which country? .....				
<b>7. Did your child have contact with a tuberculosis patient?</b>				
<b>8. Did your child have a tuberculin skin test before?</b> If so, when?..... Result positive/negative				
<b>9. Did the mother use medication during pregnancy that suppressed the immune system?</b> If so, which medication?.....				
<b>10. Was mother during pregnancy or on any other moment tested positive for HIV / Aids?</b>				

*The answers in this questionnaire will be used for medical purposes only and are part of the medical file.*