Screening Checklist for Contraindications to Vaccines for Adults

YOUR NAME _____

DATE OF BIRTH ____/____/____
month day year

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means we need to ask you more questions. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccine?	☐	☐	☐
4. Do you have any of the following: a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?	☐	☐	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
6. Do you have a parent, brother, or sister with an immune system problem?	☐	☐	☐
7. In the past 6 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☐	☐
8. Have you had a seizure or a brain or other nervous system problem?	☐	☐	☐
9. Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19?	☐	☐	☐
10. In the past year, have you received immune (gamma) globulin, blood/blood products, or an antiviral drug?	☐	☐	☐
11. Are you pregnant?	☐	☐	☐
12. Have you received any vaccinations in the past 4 weeks?	☐	☐	☐
13. Have you ever felt dizzy or faint before, during, or after a shot?	☐	☐	☐
14. Are you anxious about getting a shot today?	☐	☐	☐

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

Did you bring your immunization record card with you? **yes** ☐ **no** ☐

It is important to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

Crestwood Pediatric Associates, PC

A Division of Trusted Doctors

Patient's Name: _____ DOB: _____

Vaccines to be given today are checked to the left of the names.

	Pentacel (Dtap, IPV, HIB)		**Quadracel** (Dtap, IPV)		**Proquad** (MMR & Varicella)
	DtaP (Diptheria, Tetanus, acellular Pertussis)		**MMR** Measles, Mumps, Rubella)		**TD** (Tetanus, Diptheria)
	IPV (Inactivated Polio Vaccine)		**Varivax** (chickenpox vaccine)		**Pneumovax23** (Pneumococcal Polysaccharide)
	Hepatitis B Vaccine		**Hepatitis A Vaccine**		**Seasonal Fluzone (PF)**
	HIB (Haemophilius Influenza type B)		**Tdap** (Tetanus, Diptheria, acellular Pertussis)		**Seasonal Fluzone**
	Prevnar 13 (Pneumococcal Conjugate)		**Gardasil-9** (HPV vaccine)		**Japanese Encephalitis Vaccine**
	Rotavirus Vaccine		**MenQuadfi** (Meningococcal Conjugate Vaccine)		**Typhoid Vaccine**
	Yellow Fever Vaccine		**MenB** (Meningococcal B vaccine)		**Other:**

PRIVATE/STATE stock used (VFC elig, Ins. _____)

( )Borrowed?

A copy of the appropriate Centers for Disease Control and Prevention Vaccine information Statement was provided to me. By signing below, I agree that:

- **I have read or had explained to me the information about this disease and the vaccine.**
- **I had an opportunity to ask questions, and those questions were answered satisfactorily.**
- **I believe that I understand the benefits and risks of the vaccine.**
- **I ask that the vaccine be given to me or to the person named above (for whom I am authorized to make this request).**

Each time I sign below, I agree that all of these actions have occurred for the vaccines listed above.

_____ **Today's Date:** _____

Parent/Guardian/Patient Signature