Screening Checklist for Contraindications to Vaccines for Adults

PATIENT 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 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. 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 vaccination?	☐	☐	☐
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	☐	☐	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
6. In the past 3 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?	☐	☐	☐
7. Have you had a seizure or a brain or other nervous system problem?	☐	☐	☐
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
10. Have you received any vaccinations in the past 4 weeks?	☐	☐	☐

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

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

It is important for you 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 health care provider records all your vaccinations on it.

immunization action coalition
immunize.org

Technical content reviewed by the Centers for Disease Control and Prevention

Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

www.immunize.org/catg.d/p4065.pdf • Item #P4065 (2/16)

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