Parent/Guardian/Patient please complete

Crestwood Pediatric ASSOCIATES, PC

Patient name: _____ Date of Birth: _____

Screening Checklist for Contraindications to Vaccines for Children and Teens

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.	If your child is a baby, have you ever been told he or she has intussusception?			
7.	Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?			
8.	Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?			
9.	In the past 3 months, has the child taken medications that weaken their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?			
10.	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?			
11.	Is the child/teen pregnant or is there a chance she could become pregnant during the next month? LMP: _____			
12.	Has the child received vaccinations in the past 4 weeks?			

Form Completed By:	Date:
Form Reviewed By:	Date:

Adapted from Immunization Action Coalition; immunize.org

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