

Screening Checklist for Contraindications to Vaccines for Children and Teens

PATIENT NAME _____

DATE OF BIRTH _____
month / day / year

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 medicine, food, a vaccine component, or latex?	☐	☐	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Does the child have a long-term health problem with heart, lung (including asthma), kidney, liver, nervous system, or metabolic disease (e.g., diabetes), a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are they taking regular aspirin or salicylate medication?	☐	☐	☐
5. For children age 2 through 4 years: Has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐	☐	☐
6. For babies: Have you ever been told the child had intussusception?	☐	☐	☐
7. Has the child, a sibling, or a parent had a seizure; has the child had a brain or other nervous system problem?	☐	☐	☐
8. Has the child ever been diagnosed with a heart condition (myocarditis or pericarditis) or have they had Multisystem Inflammatory Syndrome (MIS-C) after an infection with the virus that causes COVID-19?	☐	☐	☐
9. Does the child have an immune-system problem such as cancer, leukemia, HIV/AIDS?	☐	☐	☐
10. In the past 6 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs to treat rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	☐	☐	☐
11. Does the child's parent or sibling have an immune system problem?	☐	☐	☐
12. In the past year, has the child received immune (gamma) globulin, blood/blood products, or an antiviral drug?	☐	☐	☐
13. Is the child/teen pregnant?	☐	☐	☐
14. Has the child received vaccinations in the past 4 weeks?	☐	☐	☐
15. Has the child ever felt dizzy or faint before, during, or after a shot?	☐	☐	☐
16. Is the child 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 child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.



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 (Diphtheria, Tetanus, acellular Pertussis)		MMR Measles, Mumps, Rubella)		TD (Tetanus, Diphtheria)
	IPV (Inactivated Polio Vaccine)		Varivax (chickenpox vaccine)		Pneumovax23 (Pneumococcal Polysaccharide)
	Hepatitis B Vaccine		Hepatitis A Vaccine		Seasonal Fluzone (PF)
	HIB (Haemophilus Influenza type B)		Tdap (Tetanus, Diphtheria, 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