Patient name: ______________________ Date: ______/______/ 20____

Date of birth: ______/______/______

Screening Checklist for Contraindications to Vaccines for Children and Teens

Vaccines to be given today:

- [ ] Pediarix
- [ ] PCV13
- [ ] Hib
- [ ] Rota
- [ ] DTaP
- [ ] HepA
- [ ] MMRV
- [ ] MMR
- [ ] Tdap
- [ ] MenACWY
- [ ] HPV9
- [ ] Polio
- [ ] HepB
- [ ] Kinrix
- [ ] Varicella
- [ ] Flu
- [ ] Td
- [ ] MenB
- [ ] ________

Vaccines declined today:

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.

Vaccines	Question	Yes	No
All	1 Is the child sick today?	Yes	No
All	2 Does the child have allergies to medications, food, a vaccine component, or latex?	Yes	No
All	3 Has the child had a serious reaction to a vaccine in the past?	Yes	No
MMR,MMRV VAR, LAIV	4 Does the child have long-term health problem with lung, heart, kidney, or metabolic disease (e.g. diabetes), asthma, or a blood disorder? Are they on long-term aspirin therapy?	Yes	No
LAIV	5 Ages 2 through 4 yrs: has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	Yes	No
Rotavirus	6 Babies: have you ever been told he/she has had intussusception?	Yes	No
DTaP,Td,Tdap, Flu,MMRV,LAIV	7 Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	Yes	No
MMR,MMRV, RV,VAR	8 Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problems?	Yes	No
MMR,MMRV, VAR	9 Does the child have a parent, brother, or sister with an immune system problem?	Yes	No
MMR,MMRV, VAR	10 In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	Yes	No
MMR,MMRV, VAR,LAIV	11 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?	Yes	No
MMR,MMRV, VAR,LAIV	12 Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	Yes	No
MMR,MMRV, VAR,LAIV	13 Has the child received vaccinations in the past 4 weeks?	Yes	No

By signing this form, you have read or have had explained to you the information about the immunization(s) that are to be given, and that you give permission for them to be administered. Signing this also means that you have had a chance to ask any questions that you may have regarding the vaccines to be given and that the questions were answered to your satisfaction.

"I understand the benefits and risks associated with the vaccines to be given and request the vaccines indicated to be given to me, or the patient named above for whom I am authorized to make this request."

Sign: ______________________ Date: ______/______/20____

Reviewed by: ______________________ Date: ______/______/20____

Name: ______________________

DOB: ______________________

Athena #: ______________________

Patient's Insuruance Today:

Site: R L By:

Site: R L By:

Site: R L By:

Site: R L By:

Site: R L By:

Site: R L By:

Signature of Administrator: ______________________ Date: ______________

Signature of Administrator: ______________________ Date: ______________