Evergreen Family Medicine School Exclusion Day Vaccine Event

Student Name: _____

DOB: _____

Evergreen FAMILY MEDICINE
A Division of Centennial Medical Group

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 had 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?	☐	☐	☐
12. Has the child received vaccinations in the past 4 weeks?	☐	☐	☐

Form completed by: _____ Date: _____

Form reviewed by: _____ Date: _____

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

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Vaccine Administration Record and Consent Form

Signing this form means you have read or have had explained to you the information about the immunizations 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 that the vaccines indicated to be given to me, or the patient named below for whom I am authorized to make this request."

Vaccines to be given:

- ☐ Dtap
- ☐ IPV
- ☐ HIB
- ☐ Hep B
- ☐ Hep A
- ☐ MMR
- ☐ Tdap
- ☐ Td
- ☐ Varicella
- ☐ PCV13
- ☐ HPV
- ☐ Rotavirus
- ☐ Meningococcal
- ☐ Pneumo23
- ☐ Flu
- ☐ Pentacel (Dtap/IPV/HIB
- ☐ Proquad(MMR & Varicella)
- ☐ Kinrix (Dtap/IPV 4-6yo)
- ☐ Pediarix (Dtap/IPV/Hep B)
- ☐ Twinrix (Adult Hep A / Hep B)

Signature of person receiving vaccine or authorized to make this request

Sign ______________________ Date ____________

***Office Use Only**

Vaccine: ________	Mfg: ________	Lot: ________	Exp: ________	NDC: ________	Site R or L
Vaccine: ________	Mfg: ________	Lot: ________	Exp: ________	NDC: ________	Site R or L
Vaccine: ________	Mfg: ________	Lot: ________	Exp: ________	NDC: ________	Site R or L
Vaccine: ________	Mfg: ________	Lot: ________	Exp: ________	NDC: ________	Site R or L
Vaccine: ________	Mfg: ________	Lot: ________	Exp: ________	NDC: ________	Site R or L
Vaccine: ________	Mfg: ________	Lot: ________	Exp: ________	NDC: ________	Site R or L
Vaccine: ________	Mfg: ________	Lot: ________	Exp: ________	NDC: ________	Site R or L

Signature of Administrator ______________________ Date ____________

Signature of Co-Signer ______________________ Date ____________