Screening Checklist for Contraindications To Vaccines for Adults

PATIENT NAME____

DATE OF BIRTH____

PHONE____

ADDRESS________________________________ **CITY**__________________ **STATE**________ **ZIP**________

ALLERGIES____

MOTHER'S MAIDEN NAME____

GENDER: M☐ **F**☐ **HISPANIC/LATINO?** Y☐ N☐

RACE: WHITE☐ ASIAN☐ BLACK☐ PACIFIC ISLANDER☐ NATIVE AMERICAN☐ OTHER☐

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, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?	☐	☐	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
6. Do you have a parent, brother, or sister with an immune system problem?	☐	☐	☐
7. 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?	☐	☐	☐
8. Have you had a seizure or a brain or other nervous system problem?	☐	☐	☐
9. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
10. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
11. Have you received any vaccinations in the past 4 weeks?	☐	☐	☐

FORM COMPLETED BY______________________________________ DATE____________

FORM REVIEWED BY______________________________________ DATE____________

Administration (Pharmacist Use Only)

Vaccine	Product Name	Manufacturer	Lot	Exp Date	Dose	Site of Injection	Date of VIS	Signature of Administrator of Vaccine
Influenza (TIV)	Flulaval	GSK			.5 ml	LD RD	8/7/2015	
Pneumococcal Polysaccharide (PPSV23)	Pneumovax 23	Merck			.5 ml	LD RD	4/24/2015	
Pneumococcal Conjugate (PCV13)					.5 ml	LD RD	11/5/2015	
Herpes Zoster	Shingrix	GSK			.5 ml	LD RD	2/12/2018	
Hepatitis B (Age 20+)	Engerix - B (Adult)	GSK			1 ml	LD RD	7/20/2016	
Menigococcal Conjugate (MCV4)					.5 ml	LD RD	3/31/2016	
Meningococcal Polysaccharide (MPSV4)					.5 ml	LD RD	3/31/2016	
Tetanus-Diphtheria (Td)	Tenivac	Sanofi			.5 ml	LD RD	4/11/2017	
Tetanus, Diphtheria Toxoids & Acellular Pertussis (Tdap)	Boostrix	GSK			.5 ml	LD RD	2/24/2015	