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 medications, 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 lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Is he/she on long-term aspirin therapy?	☐	☐	☐
5. If the child to be vaccinated is 2 through 4 years of age, 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. Does the child have a parent, brother, or sister with an immune system problem?	☐	☐	☐
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?	☐	☐	☐
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?	☐	☐	☐
12. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐	☐
13. Has the child received vaccinations in the past 4 weeks?	☐	☐	☐

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.

immunization action coalition
IAC
immunize.org

Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

www.immunize.org/catg.d/p4060.pdf • Item #P4060 (8/19)

CHILDREN AND HOOSIER IMMUNIZATION REGISTRY PROGRAM
(CHIRP) VACCINE ADMINISTRATION

RECORD OF PARENT/GUARDIAN OR RECEIPT SIGNATURE

I have read or had explained to me the information in the 'Vaccine Information Statement(s)" or the "Important Information Statement(s)" for the disease(s) and vaccine(s) checked below. I have had a chance to ask questions and fully understand the benefits and risks of the vaccine(s) checked below. I request that these vaccines be given to me or to the person named below.

☐DT	☐DTaP/IPV	☐ DTaP-HiB	☐ Influenza .50 ml	☐MMR	☐HEP B	☐PCV 20	☐HPV 9v
☐Td	☐DTaP/IPV/Hep B	☐IPV	☐RIV4	☐MMRV	☐HEP A	☐PCV 15	☐Rotavirus
☐Tdap	☐DTaP/IPV/HiB	☐HiB	☐Flu Mist	☐Varicella	☐HEP A (Adult)	☐PCV 13	☐MCV 4
☐DTaP	☐DTaP/IPV/HiB/Hep B		☐High Dose	☐Zoster	☐COVID-19	☐PPSV23	☐Men B

Last Name:	First:	Middle:	Gender: ☐M ☐F ☐Other	
Date of Birth:	Age:	Birth State:	Birth Country	Hoosier Healthwise #
Race: ☐White ☐African American ☐Asian ☐Multi-Racial ☐Other ☐Nat. Hawaiian, Pac. Islander. ☐American Indian			Hispanic Origin: ☐Hispanic ☐Non-Hispanic ☐Unknown	
Physician Name:		School District Reside In:		
Guardian 1 Last Name:	First:	Relationship: ☐Mother ☐Father ☐Other(specify)_____		
Guardian 2 Last Name:	First:	Mother Maiden Name:		
Mailing Address:				
Address:		Home Phone:	Work Phone:	
City:	State:	ZIP Code:	Email Address:	
Language, if other than English (specify):		Other Phone (specify):		
Clinic Use Only: Funding Source: O Medicaid O Underinsured - FQHC or RHC Only		O Uninsured O Hoosier HWise Pkg C	O Nat. American or Alaskan O Ineligible	O 317

I authorize the release of any medical or other information necessary to process this claim. I authorize payment of medical benefits to the Health Department responsible for today's services.

I agree to receive text, voice, and email messages from the Health Department to the phone number(s) and email provided above. Message and data rates may apply.

Signature of person to receive vaccine(s) or person authorized to consent to the immunization(s).

_____
Parent/Guardian/Patient Signature

_____
Printed Name

_____
Date

Children & Hoosiers Immunization Registry Program (CHIRP)

Countermeasures Injury Compensation Program (CICP)

Updated: 06/21/2023