Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME _____

DATE OF BIRTH ____/____/____
month day year

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 we need to ask you more questions. 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 ingredient, or latex?	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccine?	☐	☐	☐
4. Do you have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood clotting 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 medicines 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. 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 _____

Did you bring your immunization record card with you? yes ☐ no ☐

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

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)

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