Lincoln-Lancaster County Health Department

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 questions, 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.

VFC: ☐ **MC** ☐ **Underinsured** ☐ **Uninsured** ☐ **Alaskan/ Native American**

		Yes	No	Don't know
1	Did you bring your immunization record with you?	☐	☐	☐
2	Is the child sick today?	☐	☐	☐
3	Does the child have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
4	Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
5	Does the child have a long-term health problem with heart, lung (including asthma), kidney, liver, nervous system or metabolic disease (e.g. diabetes), a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are they taking regular aspirin or salicylate medication?	☐	☐	☐
6	For children age 2 through 4 years: Has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐	☐	☐
7	For babies: Have you ever been told the child has had intussusception?	☐	☐	☐
8	Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐	☐	☐
9	Has the child ever been diagnosed with a heart condition (myocarditis or pericarditis) or have they had Multisystem Inflammatory Syndrome (MIS-C) after an infection with the virus that causes COVID-19?	☐	☐	☐
10	Does the child have an immune-system problem such as cancer, leukemia, HIV/AIDS?	☐	☐	☐
11	In the past 6 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumotoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	☐	☐	☐
12	Does the child's parent or sibling have an immune system problem?	☐	☐	☐
13	In the past year, has the child received immune (gamma) globulin, blood/blood products, or an antiviral drug?	☐	☐	☐
14	Is the child/teen pregnant?	☐	☐	☐
15	Has the child received vaccinations in the past 4 weeks?	☐	☐	☐
16	Has the child ever felt dizzy or faint before, during, or after a shot?	☐	☐	☐
17	Is the child anxious about getting a shot today?	☐	☐	☐

I have been given or read the vaccine information sheets. □ (Please check) Refused VIS □ (Please check)

Date	x Signature of person to receive immunization(s)/vaccine(s) or person authorized to request services (parent/guardian if under 19 years of age)	Relationship (if other than self)

Name of Interpreter (if needed)	Signature of Interpreter (if needed)	Language Interpreted (if needed)

*** NOTE: This statement expires 14 days after the date this form is signed.

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www.immunize.org/catg.d/p4060.pdf item #p4060 (10/20)