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 _____

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Fluzone Lot# U8070BA          Right          Left
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High Dose Lot# UT8072CA       Right          Left
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Pfizer 12+ Lot# HD9835        Right          Left
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HURON COUNTY HEALTH DEPARTMENT

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Tip MacGuire, R.S., B.S., Health Officer / Environmental Health Director
Dr. Mark Hamed, M.D., M.B.A., M.P.H., Medical Director

Reset Form

INFORMED CONSENT

Client's Name _____

I have been given a copy and have read, or have had explained to me, the information contained on the appropriate Vaccine Information Statement (VIS) about the disease(s) and the vaccine(s) which are to be administered today. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the specific vaccine(s) and I ask that the vaccine(s) I have requested be given to me or to the person names above for whom I am authorized to make this request and I ask that the administration of the vaccine(s) be recorded in the MCIR.

I authorize Huron County Health Department to release all pertinent records to my insurance provider for filing and audit purposes for the services provided through the Huron County Health Department. I understand that my health insurance may be billed for the total cost of today's services. If my insurance does not cover the entire vaccine and administration cost, I may be billed for the uncovered portion of co-pay, deductibles, and uncovered/exhausted benefits. I understand that the Huron County Health Department may undergo random audit(s) to verify insurance coverage/fraud.

I authorize the immunization records to be released to me, parent or legal guardian until revoked in writing.

_____ _____

Client/Parent or Legal Guardian Date