

Patient Name: _____

Patient D.O.B. : _____

Screening Checklist for Contraindications to Live Virus Vaccines for Children and Teens

MMR, Varivax, Rotavirus, LAIV (Flumist)

	Yes	No	Don't Know
1. Is the child sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the child have allergies to egg, gelatin, a vaccine component or latex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the child had a serious reaction to a vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the child had a health problem with lung, heart, kidney, or metabolic disease (e.g. diabetes), asthma, or a blood disorder? Is he/she on long term aspirin therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. If the child to be vaccinated is between 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. If your child is a baby, have you ever been told he or she has had intussusception?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Does the child or a family member have cancer, leukemia, HIV/AIDS, or any other immune system problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Has the child received vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Form Completed By: _____

Date: _____

Form Reviewed By: _____

Date: _____

Patient Name: _____

Patient D.O.B. : _____

Screening Checklist for Contraindications to Inactivated Vaccines for Children and Teens

DTaP, HIB, HAV, HBV, HPV, IPV, PCV, Td, Tdap, MCV4, MenB, PPSV23

	Yes	No	Don't Know
1. Is the child sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the child have allergies to a vaccine component or latex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the child had a serious reaction to a vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Form Completed By: _____

Date: _____

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Date: _____