

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Jasmine Ladson

DATE OF BIRTH 05 / 13 / 1992
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 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. Are you sick today?	☐	☒	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☐	☒
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☒
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	☐	☒	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☒	☐
6. In the past 3 months, have you taken medications 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?	☐	☒	☐
7. Have you had a seizure or a brain or other nervous system problem?	☐	☒	☐
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☒	☐
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☒	☐
10. Have you received any vaccinations in the past 4 weeks?	☒	☐	☐

FORM COMPLETED BY Jasmine Ladson DATE 11-30-2020
FORM REVIEWED BY [Signature] DATE 11/30/20

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.

ADOLESCENT & ADULT IMMUNIZATION RECORD

Clinic: _____

Name: Tasmine Ladson

Date of Birth: 5/13/92 Record #: _____

Allergies: NKMA Reactions: _____

History of Chickenpox? YES or NO If yes, date if known: _____

Vaccine	Date Admin			Age at the time	VIS Form Given			Manuf. Abbr*	Lot Number	Dose	Admin Site**	Route	Provider Initials*** or Outside Provider Name
	Mo	Day	Yr		Type	Mo	Yr						
Td					Td			LOT: 4EA77 EXP: 09/11/22		0.5cc		IM	4F99G 08/19/22
Td					Td					0.5cc		IM	
Td					Td			NDC 59169-821-43 Hepatitis B Vaccine (Recombinant)		0.5cc		IM	Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine, Adsorbed BOOSTRIX
Td					Td			ENGRIX-B		0.5cc		IM	0.5 mL
Tdap	11	30	20		Tdap			20 mcg/mL		0.5cc	LD	IM	Mtd. by GlaxoSmithKline Biologicals
Hep B	11	30	20		Hep B			Mtd. by GlaxoSmithKline Biologicals		1.0	RD	IM	496018
Hep B					Hep B				495702			IM	
Hep B					Hep B							IM	
Hep B (booster if needed)					Hep B							IM	
MMR Rubella Rubeola					MMR					0.5cc		SQ	
MMR Rubella Rubeola					MMR					0.5cc		SQ	
Varicella					Var					0.5cc		SQ	
Varicella					Var					0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
PPV23					PPV					0.5cc		IM	
PPV23					PPV			LOT: N549A EXP: 06/30/21		0.5cc		IM	
Hepatitis A					Hep A			NDC 59169-885-41				IM	
Hepatitis A					Hep A			Influenza Vaccine				IM	
HPV					HPV			FLUARIX QUADRIVALENT 2020/2021 Formule		0.5cc		IM	
HPV					HPV			Mtd. by GlaxoSmithKline Biologicals		0.5cc		IM	
HPV					HPV					0.5cc		IM	
Influenza	11	30	20		Flu					0.5cc	LD	IM	AM
Influenza					Flu					0.5cc		IM	
Influenza					Flu					0.5cc		IM	
MCV4					Mening							IM	
MPSV4					Mening							SQ	

* Manufacturers: M= Merck; S = Sanofi Pasteur; W = Wyeth; G = GlaxoSmithKline

** Sites: LT = Left Thigh, RT = Right Thigh, LA = Left Arm, RA = Right Arm, LD = Left Deltoid, RD = Right Deltoid

*** VIS Language given, if not English: _____