

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Sandy Thrash
DATE OF BIRTH 6 / 22 / 1967
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 Sandra Thrasher DATE 11/16/18
FORM REVIEWED BY [Signature] 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.

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Sandy Thrasher
DATE OF BIRTH 06/22/1967
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.

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FORM COMPLETED BY Sandy Thrasher DATE 5/24/18
FORM REVIEWED BY [Signature] DATE 5/24/18

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

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ADOLESCENT & ADULT IMMUNIZATION RECORD

Clinic: _____

Name: Sandra Thrasher

Date of Birth: 6/22/67 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 No.	Admin Site**	Route	Provider Initials*** or Outside Provider Name
	Mo	Day	Yr		Type	Mo	Yr					
Td					Td				3HG77 07/03/20		IM	
Td					Td						IM	
Td					Td						IM	
Td					Td						IM	
Tdap					Tdap						IM	
Hep B + Hep A	4	27	18		Hep B	7	16	GSK		LD	IM	AM
Hep B + Hep A	5	24	18		Hep B	7	16	GSK	95KG9 10/29/20	LD	IM	AM
Hep B + Hep A	11	16	18		Hep B	7	16	GSK		LD	IM	AM
Hep B (booster if needed)					Hep B						IM	
MMR Rubella Rubeola					MMR						SQ	
MMR Rubella Rubeola					MMR						SQ	
Varicella					Var						SQ	
Varicella					Var						SQ	
IPV					Polio						SQ	
IPV					Polio						SQ	
IPV					Polio						SQ	
IPV					Polio						SQ	
PPV23					PPV						IM	
PPV23					PPV						IM	
Hepatitis A					Hep A						IM	
Hepatitis A					Hep A						IM	
HPV					HPV						IM	
HPV					HPV						IM	
HPV					HPV						IM	
Influenza					Flu						IM	
Influenza					Flu						IM	
Influenza					Flu						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: _____

AM - Amy M RN

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DATE OF BIRTH 6/22/67
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FORM COMPLETED BY Sandra Thrasher DATE 4/27/18
FORM REVIEWED BY [Signature] DATE 4/27/18

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

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