

Insurance ID # _____ RX BIN: _____ RX PCN: _____ RX GRP: _____ Medicare # _____	Ethnicity: _____ Caucasian _____ African American _____ Asian/Pacific Islander _____ Hispanic _____ Native American _____ Other: _____	Vaccine Requested: _____ Flu _____ RSV _____ Hi-Dose Flu _____ COVID _____ Shingrix _____ Pneumonia _____ T-Dap _____ Vitamin B
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SCREENING CHECKLIST FOR CONTRAINDICATIONS TO VACCINES FOR ADULTS

Last Name (Please print)		First Name	MI	Date of Birth	☐ Male ☐ Female ☐ Other _____
Address			City	ST	Zip
Phone Number	Email		Name of Primary Care Provider		

SCREENING FOR VACCINATION ELIGIBILITY

1. Are you currently sick (e.g. fever, chills, cough, shortness of breath, body ache, etc)?	Yes	No
2. Do you have allergies to medications, food, a vaccine component, or latex?	Yes	No
3. Have you had a severe allergic reaction (e.g. anaphylaxis, trouble breathing) to any vaccine or injectable therapy, or a history of anaphylaxis due to any cause?	Yes	No
4. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	Yes	No
5. Have you received any other vaccine within the past 14 days or are you schedule to receive any vaccine in the next 14 days?	Yes	No
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 treatment?	Yes	No
7. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	Yes	No
8. Do you have a parent, brother, or sister with an immune system problem?	Yes	No
9. Have you had a seizure or a brain or other nervous system problem?	Yes	No
10. Do you have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g. diabetes), asthma, blood disorder, no spleen, complement component deficiency, cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?	Yes	No
11. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	Yes	No

CONSENT FOR VACCINATION

I will/have reviewed my answers to the questions above with the vaccinator. If I experience any adverse reactions after leaving, I will notify my primary care provider. I have viewed the Emergency Use Authorization Fact Sheet provided to me today. I understand the benefits and risks of the vaccine.

The vaccine checked above should be given to the person named above for whom I am authorized to make this request. I understand that I can review a Notice of Privacy Practice at the time of vaccination.

Signature of Parent/Guardian/Patient _____ Date _____

Vaccine	Date Vaccine and EUA Given	Route In <i>R L</i>	Manufacturer	Lot No.	Printed Name and Signature of Vaccine Administrator
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