PediatriCare Associates
Pediatric and Adolescent Medicine

PATIENT NAME _____ DATE OF BIRTH: ____/_____/_____

Screening Checklist for Contraindications for Vaccines for Children

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any questions, it does not necessarily mean your child 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
1. Has your child had fever in the past 48 hours?	☐	☐
2. Does your child have allergies to a vaccine component or latex?	☐	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☐
4. Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), or a blood disorder? Is he/she on long-term aspirin therapy?	☐	☐
5. 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?	☐	☐
6. Is the teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐

FORM COMPLETED BY ***PARENT***:_____ DATE_____

FOR OFFICE USE ONLY

VACCINE(S) REVIEWED BY ***PHYSICIAN***:_____ DATE_____

VACCINE(S) TO BE GIVEN:_____ DATE_____

VACCINE(S) GIVEN BY ***NURSE***:_____ DATE_____

(updated 9/1/20)

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