PediatriCare Associates

Pediatric and Adolescent Medicine

PATIENT NAME _____

DATE OF BIRTH____/_____/_____

Screening Checklist for Contraindications for Vaccines for Teens

For parents/guardians: The following questions will help us determine which vaccines your teenager may be given today. If you answer "yes" to any question, it does not necessarily mean your teen 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 5 days? Does your teenager have cold symptoms or other signs of illness?	☐	☐
2. Does the teenager 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), asthma 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?	☐	☐
7. Do you want to see the doctor?	☐	☐

FORM COMPLETED BY_____DATE_____

FORM REVIEWED BY_____DATE_____

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