Parent/Guardian/Patient please complete

Crestwood Pediatric ASSOCIATES, PC

Patient name: _____ Date of Birth:_____

Screening Checklist for Contraindications to Vaccines for Children and Teens

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, 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	Don't Know
1.	Is the child sick today?			
2.	Does the child have allergies to medications, food, 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.	If the child to be vaccinated is between the ages of 2 and 4 years, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?			
6.	If your child is a baby, have you ever been told he or she has intussusception?			
7.	Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?			
8.	Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?			
9.	In the past 3 months, has the child taken medications that weaken their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?			
10.	In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?			
11.	Is the child/teen pregnant or is there a chance she could become pregnant during the next month? LMP:_____			
12.	Has the child received vaccinations in the past 4 weeks?			

Form Completed By:	Date:
Form Reviewed By:	Date:

Adapted from Immunization Action Coalition; immunize.org