Cherry Health

Screening Checklist for Contraindications to Vaccines

Patient Name: _____ Date of Birth: _____ / _____ / _____

For patients or parents/guardians: The following questions will help us decide which vaccines you or your child can receive today. If you answer "yes" to any question, it does not necessarily mean you or your child should not be vaccinated. It just means we need to ask additional questions. Please ask your healthcare provider to explain if any of the questions are unclear.

Answer each question for the person being vaccinated today.	Yes	No	Unsure
1. Is the patient sick today?			
2. Does the patient have allergies to medications, food, a vaccine ingredient, or latex?			
3. Has the patient ever had a serious reaction after receiving any vaccine?			
4. Does the patient have long-term health problem with heart, lung, kidney, metabolic disease (ie. Diabetes), asthma, a blood clotting disorder, no spleen, complement component deficiency, cochlear implant, or spinal fluid leak? Is the patient on long-term aspirin therapy?			
5. Does the patient have cancer, leukemia, HIV/AIDS, or any other immune system problem?			
6. Does the patient have a sibling or parent with an immune system problem?			
7. In the past 6 months, has the patient taken medicines 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 had radiation treatment?			
8. Has the patient had a seizure? Any brain or other nervous system problem? Has a sibling or parent of the patient had any seizures?			
9. In the past year, has the patient received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?			
10. Is the patient pregnant or chance of pregnancy during the next month?			
11. Has the patient received any vaccinations in the past 4 weeks?			
12. Has the patient ever felt dizzy or faint before, during or after a shot?			
13. Is the patient anxious about getting a shot?			
14. For children between the ages of 2-4 years old, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?			
15. For babies between the ages of birth-8 months old, have you ever been told he/she has had intussusception?			
16. Has the patient ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19?			

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For injectable influenza vaccination, please answer the following question.	Yes	No	Unsure
17. Has the patient ever had Guillain-Barre syndrome?			

For intranasal influenza vaccination, please answer the following questions.	Yes	No	Unsure
18. Is the patient younger than age 2 or older than age 49?			
19. Has the patient ever had Guillain-Barre syndrome?			
20. Does the patient live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (ie. An isolation room of a bone marrow transplant unit)?			
21. Is the person to be vaccinated currently taking influenza antiviral medications, or have they taken any within the past 3 weeks?			

Eligibility for COVID-19 vaccination is determined under the CME Standing Recommendation 2025-01.

Staff must provide patient/parent/guardian with an updated vaccine record after vaccinations have been administered.

Patient/guardian signature: _____ Date: _____

Important note for clinical support staff: The completed Screening Checklist for Contraindications to Vaccines must be reviewed and signed prior to administering any vaccines. If the patient answers yes to any of the questions on the form, other than #13, the medical clinician or RN must sign the form after reviewing for contraindications. The MA can sign the form only if the patient answers no to all questions.

Form reviewed by: _____

Resources:

https://www.immunize.org/handouts/screening-vaccines.asp