**Screening Checklist for Contraindications to Vaccines for**

***Adults***

For patients:

The following questions will help us determine which vaccines you may be given today. If you answer “yes” to any question, it does not necessarily mean you should not be vaccinated. It just means we need to ask you more questions. If a question is not clear, please ask your healthcare provider to explain it.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Yes** | | **No** | **Don’t Know** | |
| 1. Are you sick today? | □ | □ | | | □ |
| 1. Do you have allergies to medications, food, a vaccine component, or latex? | □ | □ | | | □ |
| 1. Have you ever had a serious reaction after receiving a vaccine? | □ | □ | | | □ |
| 1. Do you have any of the following: a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy? | □ | □ | | | □ |
| 1. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? | □ | □ | | | □ |
| 1. Do you have a parent, brother, or sister with an immune system problem? | □ | □ | | | □ |
| 1. In the past 6 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 treatments? | □ | □ | | | □ |
| 1. Have you had a seizure or a brain or other nervous system problem? | □ | □ | | | □ |
| 1. Have you 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? | □ | □ | | | □ |
| 1. In the past year, have you received immune (gamma) globulin, blood/blood products, or an antiviral drug? | □ | □ | | | □ |
| 1. Are you pregnant? | □ | □ | | | □ |
| 1. Have you received any vaccinations in the past 4 weeks? | □ | □ | | | □ |
| 1. Have you ever felt dizzy or faint before, during, or after a shot? | □ | □ | | | □ |

**Please check (**✔**)** **the vaccine(s) you plan to receive today: influenza** □ **COVID-19** □

***By signing below, you give consent to be vaccinated by The Corvallis Clinic staff and acknowledge that you have read the vaccine information statement (VIS) for any applicable vaccines and understand the risks and benefits.***

Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Name (print) DOB Signature* ***(patient or legal guardian****) Today’s Date*

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***Adults***

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **CLINIC USE ONLY** | | | | | | | |
| **Mfr.** | **Vaccine** | | **Dose** | **Site** | **Location** | **VIS Date** | **Lot # / Exp. Date** |
| **Private Vaccines** | | | | | | | |
|  |  | **(≥6m)** | **0.5 mL** | Deltoid | Vastus Lateralis | R | L | 01/31/2025 | **Lot # \_\_\_\_\_\_\_\_\_\_\_\_**  **Exp. Date \_\_\_\_\_\_\_\_\_\_\_\_** |
|  |  | **(≥65yr)** | **0.5 mL** | Deltoid | Vastus Lateralis | R | L | 01/31/2025 | **Lot # \_\_\_\_\_\_\_\_\_\_\_\_**  **Exp. Date \_\_\_\_\_\_\_\_\_\_\_\_** |
|  | (2025-2026 Formula) | **(≥12yr)** | **0.3 mL**  (30 mcg) | Deltoid | Vastus Lateralis | R | L | 01/31/2025 | **Lot # \_\_\_\_\_\_\_\_\_\_\_\_**  **Exp. Date \_\_\_\_\_\_\_\_\_\_\_\_** |
| **VFC Vaccines** | | | | | | | |
|  |  | **(≥6m)** | **0.5 mL** | Deltoid | Vastus Lateralis | R | L | 01/31/2025 | **Lot # \_\_\_\_\_\_\_\_\_\_\_\_**  **Exp. Date \_\_\_\_\_\_\_\_\_\_\_\_** |
|  |  | **(≥6m)** | **0.5 mL** | Deltoid | Vastus Lateralis | R | L | 01/31/2025 | **Lot # \_\_\_\_\_\_\_\_\_\_\_\_**  **Exp. Date \_\_\_\_\_\_\_\_\_\_\_\_** |
|  | (2025-2026 Formula) | **(≥12yr)** | **0.3 mL**  (30 mcg) | Deltoid | Vastus Lateralis | R | L | 01/31/2025 | **Lot # \_\_\_\_\_\_\_\_\_\_\_\_**  **Exp. Date \_\_\_\_\_\_\_\_\_\_\_\_** |

Administered by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­

*Name (print) Signature Today’s* ***Date*** *&* ***Time***