**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? | □ | □ | | | □ |
| 1. Does the child have allergies to medicine, food, a vaccine component, or latex? | □ | □ | | | □ |
| 1. Has the child had a serious reaction to a vaccine in the past? | □ | □ | | | □ |
| 1. Does the child have a long-term health problem with heart, lung (including asthma), kidney, liver, nervous system, or metabolic disease (e.g., diabetes), a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are they taking regular aspirin or salicylate medication? | □ | □ | | | □ |
| 1. For children age 2 through 4 years: Has a healthcare provider told you that the child had wheezing or asthma in the past 12 months? | □ | □ | | | □ |
| 1. For babies: Have you ever been told the child had intussusception? | □ | □ | | | □ |
| 1. Has the child, a sibling, or a parent had a seizure; has the child had a brain or other nervous system problem? | □ | □ | | | □ |
| 1. Has the child ever been diagnosed with a heart condition (myocarditis or pericarditis) or have they had Multisystem Inflammatory Syndrome (MIS-C) after an infection with the virus that causes COVID-19? | □ | □ | | | □ |
| 1. Does the child have an immune-system problem such as cancer, leukemia, HIV/AIDS? | □ | □ | | | □ |
| 1. In the past 6 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs to treat rheumatoid arthritis, Crohn’s disease, or psoriasis; or had radiation treatments? | □ | □ | | | □ |
| 1. Does the child’s parent or sibling have an immune system problem? | □ | □ | | | □ |
| 1. In the past year, has the child received immune (gamma) globulin, blood/blood products, or an antiviral drug? | □ | □ | | | □ |
| 1. Is the child/teen pregnant? | □ | □ | | | □ |
| 1. Has the child received vaccinations in the past 4 weeks? | □ | □ | | | □ |
| 1. Has the child 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* ***(parents or legal guardian****) Today’s Date*

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|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 \_\_\_\_\_\_\_\_\_\_\_\_** |
| (gray cap & border) | (2025-2026 Formula) | **(≥12yr)** | **0.3 mL**  (30 mcg) | Deltoid | Vastus Lateralis | R | L | 01/31/2025 | **Lot # \_\_\_\_\_\_\_\_\_\_\_\_**  **Exp. Date \_\_\_\_\_\_\_\_\_\_\_\_** |
|  | (2025-2026 formula) | **(6m-11yr)** | **0.25 mL**  **(25 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 \_\_\_\_\_\_\_\_\_\_\_\_** |
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Administered by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­

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