

Contraindication & Precaution Vaccination Screening Form

Name _____

MR# _____

How did you hear about us?
<input type="checkbox"/> Family/Friend <input type="checkbox"/> Flyer <input type="checkbox"/> Newspaper <input type="checkbox"/> Media <input type="checkbox"/> Website <input type="checkbox"/> Banner <input type="checkbox"/> Other _____

General Medical Questions	Yes	No
1. Do you have a fever or feel sick today?		
Inactivated Influenza Vaccines (TIV or Novel H1N1)IM	Yes	No
1. Have you ever had a severe reaction to the flue vaccine or to a component in the vaccine?		
2. Do you have a severe allergy to eggs?		
3. Do you have a severe allergy to thimerosal, a preservative used in some vaccines?		
4. Do you have a severe allergy to latex?		
5. Have you ever had Guillain-Barré Syndrome (GBS)?		
Live Attenuated Influenza Vaccines (LAIV or Live Novel H1N1)NASAL	Yes	No
1. Have you ever had a severe reaction to an intranasal flu vaccine (FluMist)?		
2. Do you have a serious allergy to eggs or to other components in the vaccine (MSG, arginine, gentamicin, and gelatin)?		
3. Are you younger than age 2 years, or older than age 49 years?		
4. Are you pregnant or planning to become pregnant in the next month?		
5. Do you have a long term medical condition such as heart disease, lung disease, asthma, metabolic disease (such as diabetes), liver disease (cirrhosis), kidney disease, a blood disorder (leukemia, lymphoma, sickle cell disease)?		
6. Do you have a weakened immune system due to HIV/AIDS or other diseases affecting the immune system, or long-term steroid therapy, or cancer treatment with drugs or x-rays?		
7. Do you have a muscle or nerve disorder that can lead to breathing or swallowing problems such as a seizure disorder or cerebral palsy?		
8. If you are between age 2 and 4 years 11 months old, in the past 12 months has a health care provider ever said that you had wheezing or asthma?		
9. If you are under 18 years old, are you currently receiving long term aspirin therapy or medicine containing aspirin?		
10. Have you received MMR (measles-mumps-rubella) or Varicella (chicken pox) vaccine, or a live influenza vaccine within the last 4 weeks?		
11. Have you ever had Guillain-Barré Syndrome (GSB)?		
12. Do you live with or are you in close contact with a person who has a severely weakened immune system who must be in a protective environment such as a hospital room with reverse air flow (for example a bone marrow transplant unit)?		

Signature _____

Date _____