Screening Checklist for Contraindications to Vaccines for Children and Teens

patient name _____

date of birth ____/____/____
month day year

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 medicine, food, a vaccine component, or latex?	☐	☐	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Does the child have a long-term health problem with heart, lung, kidney, spleen (e.g. sickle cell disease), or metabolic disease (e.g., diabetes), asthma, a blood disorder, a cochlear implant, or a spinal fluid leak, or thymus gland disorder? Is he/she on long-term aspirin therapy?	☐	☐	☐
5. 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?	☐	☐	☐
6. For babies: Have you ever been told that the child had intussusception (intestine slides into itself)?	☐	☐	☐
7. Has the child, a sibling, or a parent had a seizure; has the child had a brain or other nervous system problem (e.g. Guillain-Barre Syndrome (GBS)?	☐	☐	☐
8. 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?	☐	☐	☐
9. Does the child have an immune-system problem such as cancer, leukemia, HIV/AIDS?	☐	☐	☐
10. 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?	☐	☐	☐
11. Does the child's parent or sibling have an immune system problem?	☐	☐	☐
12. In the past year, has the child received immune (gamma) globulin, blood/blood products, or an antiviral drug?	☐	☐	☐
13. Is the child/teen pregnant, breastfeeding or is there a chance of pregnancy during the next month?	☐	☐	☐
14. Has the child received vaccinations in the past 4 weeks?	☐	☐	☐
15. Has the child ever felt dizzy or faint before, during, or after a shot?	☐	☐	☐
16. Is the child anxious about getting a shot today?	☐	☐	☐
17. Has the child had a history of COVID-19 disease in the last 3 months?	☐	☐	☐

form completed by _____ date _____

form reviewed by _____ date _____

Did you bring additional immunization records with you? **yes** ☐ **no** ☐

Adapted from:

Immunize.org

OTTAWA COUNTY DEPARTMENT OF PUBLIC HEALTH
AUTHORIZATION FOR NON-PARENT/NON-GUARDIAN
CONSENT FOR IMMUNIZATIONS

I hereby consent for my child _____

to be immunized by the Ottawa County Department of Public Health. I also authorize

_____ to

accompany my child for such immunizations and to sign the consent to treat and HIPAA documents.

I have read and completed the SCREENING CHECKLIST FOR CONTRAINDICATIONS TO VACCINES FOR CHILDREN & TEENS forms on the reverse side of this consent form. I have had a chance to ask questions by calling the Ottawa County Department of Public Health. I ask that the vaccines (s) I have requested be given to the child/teen named above for whom I am authorized to make this request. and I believe I understand the benefits and risks of the specific vaccine (s) being given to my child. Vaccine Information Statements and other vaccine information will be provided at the time of the appointment.

This consent form should be signed and dated, and the screening questionnaire Completed within 24 hours prior to your child receiving the vaccine(s).

_____ _____

Parent/Legal Guardian Signature Date

If you have any questions or concerns, please call:
Ottawa County Department of Public Health
(616) 396-5266