Family Physicians of O'Fallon

IMMUNIZATION CONTRAINDICATION CHECKLIST / VACCINE ADMINISTRATION RECORD

NAME OF VACCINE RECIPIENT: ____ Doctor: _____________

Patient's SSN____ Patient's DOB________________________

1. Is client sick (with an illness other than a cold?) Y N
2. Has client had a fever of 100 degrees or greater during the last 24 hours? Y N
3. Has client received an immunization within the last 30 days or a TB skin test within the last 3 days? Y N
4. Does the client have a disease that lowers the body's resistance to infections, such as leukemia, lymphoma, generalized malignancy, Guillain Barre Syndrome or AIDS? Y N
5. Is client being treated with drugs / medications, such as cortisone or prednisone, chemotherapy or radiation, that lower the body's resistance to infections? Y N
6. Does the client live in the same household with anyone who has a condition that lowers the body's resistance to infection? Y N
7. Is client allergic to an antibiotic called neomycin, thimerosal or allergic to eggs (swelling of the mouth or throat, difficulty in breathing, shock)? Y N
8. Has client had a blood or plasma transfusion or received immune globulin within the last three months? Y N
9. Is the client pregnant or planning pregnancy within the next 3 months? Y N
10. Has the client ever had a reaction to a previous immunization such as fever greater than 105 degrees, convulsions, total collapse or shock, a high-pitched cry or screaming episode of 3 hours or more, severe itching rash or anaphylactic allergic reaction? Y N
11. I have read and understand the other possible side effects, described in the "Vaccine Information Pamphlets" or "Important Information Statements," that could be caused by the vaccine(s). Y N
12. Does patient's insurance cover vaccines? Y N

Patient / Legal Guardian Signature____ Date ____________________

Nurse or Administrator ____ Date ____________________

Co-signer____

Vaccine_________Site___________Route ______Amt________Lot#_______________Expired___________Manf_________

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