

Screening Checklist for Contraindications to Vaccines

1. Are you feeling sick today?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
2. Are you anxious about your shot today?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
3. Have you ever been told you have an allergy and/or a serious reaction to any food (eggs or chicken protein), medication, vaccine component, or latex?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
4. Have you or any family relative ever had a serious adverse reaction after a vaccination?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
5. Have you received any vaccinations in the past 4 weeks?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
6. Have you ever felt dizzy or faint before, during or after a shot?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
7. 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?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
8. Do you have a long-term health problem with lungs, heart, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
9. Do you have or have you had cancer, HIV/AIDS, or any other immune system problems? For example, leukemia, lymphoma, cellular immune deficiencies, chronic lymphoproliferative conditions, or if you have ever received a stem cell transplants.	YES <input type="checkbox"/>	NO <input type="checkbox"/>
10. Do you have a parent, brother, or sister with an immune system problem?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
11. In the past 6 months, have you taken medicines 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?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
12. During the past year, have you received a transfusion of blood or blood products, been given immune gamma globulin or an antiviral drug?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
13. Have you, a sibling, or a parent had a seizure; had a brain/other nervous system problem?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
14. Have you ever been diagnosed with Guillain-Barre Syndrome?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
15. Are you pregnant or is there a chance you could become pregnant during the next month?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
16. Are you breastfeeding?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
<u>CHILDREN AND TEEN VACCINATION ONLY</u>		
17. Does your baby weigh less than 9 pounds?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
18. If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
19. If your child is a baby, have you ever been told he or she has had intussusception?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
<u>YELLOW FEVER VACCINATION ONLY</u>		
20. Have you ever reacted to a previous yellow fever vaccine?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
21. Are you taking any medicines (now or within the last year) that affect your immune system? For example, steroids, biological or non-biological immune modulating medicines, treatment following an organ transplant.	YES <input type="checkbox"/>	NO <input type="checkbox"/>
22. Are you receiving or have you received (within the last year) chemotherapy or radiotherapy?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
23. Have you ever been told that you may have a problem with your thymus gland (including myasthenia gravis or a thymoma)?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
24. Have you had an operation to remove your thymus gland (thymectomy) for any reason including during cardiac surgery?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
25. Have you ever had open chest surgery?	YES <input type="checkbox"/>	NO <input type="checkbox"/>