IMMUNIZATION CONTRAINDICATION CHECKLIST

MUST BE COMPLETED EACH TIME A CLIENT RECEIVES SHOTS

NAME ____ AGE: ______________

1. Is client sick with illness other than a cold? If yes, please indicate. 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 or TB skin test in the last 30 days? Y N

4. Does client have a disease that lowers the body's resistance to infections, such as leukemia, lymphoma, generalized malignancy or AIDS? Y N

5. Is client being treated with drug/Medications, such as cortisone or prednisone, chemotherapy or radiation, that lower the body's resistance to infections? Y N

6. Does 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 eggs, had swelling of the mouth or throat, hives, difficulty in breathing, (Re: IPV, Streptomycin, or polymyxin-B)? Y N

8. Has client had a blood or plasma transfusion or received immune globulin within the last 3 months? Y N

9. Has client ever had convulsions or neurological problems? Y N

10. Is client pregnant or planning pregnancy within the next three months? Y N

11. Has client had a reaction to previous immunizations, such as a fever greater than 105, convulsions, total collapse, shock, high-pitched cry or screaming episode of 3 hours or more, severe itching rash, or anaphylactic allergic reaction? Y N

X ____ / __________________

Patient/Parent/Legal/ Guardian Signature Date

X ____ / __________________

Nurse Reviewing Form Date

CHAMPAIGN-URBANA PUBLIC HEALTH DISTRICT 710 N. Neil St. Champaign, IL 61824

I have been given the "Vaccine Information Statements" or "Important Information statements" checked off on this page, have read them, and understand the possible vaccine side effects.

X ______________________________ / ________ ___________________________ / ___________
Patient/Parent/Legal Guardian Signature Date Client Last, First DOB

[ ] **TD 6-10-94 VIS**
Date: ______________Dose # : _________
Manufacturer: _______Site/Route: _______
Lot #: ______________Exp. Date: _______
Administrator/Tile: ____________________

[ ] **Hep B/HIB 7-11-01/12-16-98 VIS**
Date: ______________ Dose # : _________
Manufacturer: _______ Site/Route: _______
Lot #: ______________ Exp. Date: _______
Administrator/Tile: ____________________

[ ] **DTaP 7-30-01 VIS**
Date: ______________Dose # : _________
Manufacturer: _______Site/Route: _______
Lot #: ______________Exp. Date: _______
Administrator/Tile: ____________________

[ ] **Hep A/B 8-4-04/7-11-01 VIS**
Date: ______________ Dose # : _________
Manufacturer: _______ Site/Route: _______
Lot #: ______________ Exp. Date: _______
Administrator/Tile: ____________________

[ ] **IPV 1-1-2000 VIS**
Date: ______________Dose # : _________
Manufacturer: _______Site/Route: _______
Lot #: ______________Exp. Date: _______
Administrator/Tile: ____________________

[ ] **PCV 7 9-30-02 VIS**
Date: ______________ Dose # : _________
Manufacturer: _______ Site/Route: _______
Lot #: ______________ Exp. Date: _______
Administrator/Tile: ____________________

[ ] **Pedsvax**
[ ] **HIB 12-16-98 VIS**
Date: ______________Dose # : _________
Manufacturer: _______Site/Route: _______
Lot #: ______________Exp. Date: _______
Administrator/Tile: ____________________

[ ] **Varicella 12-16-98 VIS**
Date: ______________ Dose # : _________
Manufacturer: _______ Site/Route: _______
Lot #: ______________ Exp. Date: _______
Administrator/Tile: ____________________

[ ] **Hep A 8-4-04 VIS**
Date: ______________Dose # : _________
Manufacturer: _______Site/Route: _______
Lot #: ______________Exp. Date: _______
Administrator/Tile: ____________________

[ ] **MMR 1-15-03 VIS**
Date: ______________ Dose # : _________
Manufacturer: _______ Site/Route: _______
Lot #: ______________ Exp. Date: _______
Administrator/Tile: ____________________

[ ] **Hep B (Peds) 7-11-01 VIS**
Date: ______________Dose # : _________
Manufacturer: _______Site/Route: _______
Lot #: ______________Exp. Date: _______
Administrator/Tile: ____________________

[ ] **OTHER ___________ VIS date _________**
Date: ______________ Dose # : _________
Manufacturer: _______ Site/Route: _______
Lot #: ______________ Exp. Date: _______
Administrator/Tile: ____________________

[ ] **Hep B (Adult) 7-11-01 VIS**
Date: ______________Dose # : _________
Manufacturer: _______Site/Route: _______
Lot #: ______________Exp. Date: _______
Administrator/Tile: ____________________

[ ] **OTHER ___________ VIS date _________**
Date: ______________ Dose # : _________
Manufacturer: _______ Site/Route: _______
Lot #: ______________ Exp. Date: _______
Administrator/Tile: ____________________

*Site: RD = Right Deltoid LD = Left Deltoid RT = Right Thigh LT = Left Thigh *Route IM = Intramuscular SC = Subcutaneous 9/04