CLINIC CONTRAINDICATION CHECKLIST

NAME OF RECIPIENT_____

		YES	NO
1.	**Is the recipient sick (worse than a cold)?**	_____	_____
2.	**Has the recipient had a fever in the last 24 hours? Temperature reading_____**	_____	_____
3.	**Has the recipient had a shot within the last 30 days?**	_____	_____
4.	**Is the recipient going to have a tuberculosis skin test in the next 30 days?**	_____	_____
5.	**Does the recipient have a disease that makes it harder to fight off infections (leukemia, AIDS, cancer or any other immune system problem)?**	_____	_____
6.	**Is the recipient or any person living with the recipient taking cortisone, prednisone, other steroids, anticancer drugs or radiation treatments?**	_____	_____
7.	**For Women:** **Is the recipient pregnant or planning pregnancy within the next 3 months?** **If pregnant, is the recipient breast feeding?**	_____ _____	_____ _____
8.	**Does the recipient have any allergies (in particular neomycin, yeast, bread, gelatin, thimerosol, eggs, polymyxin B, streptomycin)?**	_____	_____
9.	**Has the recipient during the past year received blood or plasma or been given a medicine called immune globulin?**	_____	_____
10.	**Has the recipient ever had seizures or other neurologic problems?**	_____	_____
11.	**Has the recipient ever had a problem after any immunization such as fever greater than 104 degrees, a high pitched cry, screaming for more than 3 hours, a rash, or any other type of reaction?**	_____	_____
12.	**Does the recipient have an altered immune system, chronic gastrointestinal disease, or a history of bowel intussception?**	_____	_____
13.	**I understand the questions listed above as well as information provided on the Vaccine Information Statements.**	_____	_____

If your answer to number 13 is no, consult with a nurse before immunization is given.

I have read, understood and had an opportunity to ask questions concerning the above information and agree to remain in the clinic area for 15 minutes after the vaccine is administered.

Doctor's Name_____Address_____

Signature of Recipient (if 18 or older)_____Date____/____/____

If under 18:
Signature of Parent or Legal Guardian_____Date____/____/____

Phone # _____

Signature of Nurse providing immunization_____