Morgan County Health Department
4275 N St Rt 376 NW
McConnelsville, OH 43756
Phone: 740-962-4572
Fax: 740-962-3271

Screening Checklist for Contraindications to Vaccines for ADULT

PATIENT NAME: ______________________________

DATE OF BIRTH: ________ /_________ /_________

	Yes	No	Unknown
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, food, or any vaccine?	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4. Do you have cancer, leukemia, AIDS, or any other immune? system problem?	☐	☐	☐
5. Do you take cortisone, prednisone, other steroids, anticancer drugs, or have you had x-ray treatments?	☐	☐	☐
6. During the past year, have you received a transfusion of blood or, blood products, or been given a medicine call immune (gamma) globulin?	☐	☐	☐
7. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
8. Have you received any vaccinations in the past 4 weeks, or received a Tetanus vaccine in the last 2 yrs.?	☐	☐	☐

IF YES, WHAT VACCINATION______________________________________

9. **As of today's, visit:**

☐I have no insurance or,
☐My insurance does not pay for vaccines

Form completed by (PRINT): ____________________Signature: ____________________

Form reviewed by (Nurse): ______________________________ Date: ________________

It is important for you to have a personal record of your vaccinations. If you don't have a record card, ask your health care provider to give you one! Bring this record with you every time you seek medical care. Make sure your health care provider records all your vaccinations on it.
SIGNATURE NEEDED ON REVERSE SIDE