COVID-19 and Flu Screening Checklist for Contraindications to Vaccines for Adults & Children

Name: ________________________________ **DOB:** __________________ **Age Today:** __________

Address: ____ **Ph#:** ______________________

The following questions will help us determine if there is any reason a vaccine cannot be given today. If you answer "yes" to any question, it does not necessarily mean the vaccine cannot be given. It just means additional questions may be asked. If a question is not clear, please ask a healthcare provider to explain it.	Yes	No	Unsure
1. Are you sick today?			
2. Do you have allergies to medication, food, a vaccine component, or latex?			
3. Have you ever had an immediate serious reaction after receiving a vaccine?			
4. Are you moderately or severely immunocompromised due to one or more of the medical conditions or receipt of immunosuppressive medications or treatments listed below? 1) Active treatment for solid tumor, 2) Hematologic malignancies, 3) Hematologic malignancies associated with poor responses to COVID-19 vaccines regardless of current treatment status (e.g., chronic lymphocytic leukemia, non-Hodgkin lymphoma, multiple myeloma, acute leukemia) 4) Receipt of solid-organ transplant and taking immunosuppressive therapy, 5) Receipt of CAR-T-cell or hematopoietic stem cell transplant (within 2 years of transplantation or taking immunosuppression therapy), 6) Moderate or severe primary immunodeficiency (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome), 7) Advanced or untreated HIV infection, 8) Active treatment with high-dose corticosteroids (i.e., 20 mg prednisone or equivalent per day), alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, cancer chemotherapeutic agents classified as severely immunosuppressive, tumor-necrosis (TNF) blockers, and other biologic agents that are immunosuppressive or immunomodulatory.			
5. Have you ever had Guillain-Barre Syndrome?			
6. In the past year, have you received immune (gamma) globulin, blood/blood products, or an antiviral drug?			
7. Are you pregnant?			
8. Have you received any vaccinations in the past 4 weeks?			
9. Have you ever felt dizzy or faint before, during, or after a shot?			
10. Are you anxious about getting a shot today?			
11. In the last 10 days have you had a COVID-19 test because you had symptoms, or been told by a health care provider to isolate at home due to infection or exposure?			
12. Is the person to be vaccinated younger than age 2 or older than 49?			
13. Does the person to be vaccinated have a) an open channel between the cerebrospinal fluid (CSF) and the mouth, throat, nose or ear or any other cranial CSF leak, or b) a cochlear implant, or c) an immunocompromising condition due to any cause (e.g., medication, congenital or acquired immunodeficiency, HIV infection, or a missing or non-functioning spleen [e.g., caused by sickle cell disease])			
14. Has the person to be vaccinated a child or teen age 6 months through 17 years and receiving aspirin- or salicylate-containing medicine?			
15. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)			
16. Are you 12 years of age or older and have you received a complete COVID-19 vaccine primary series (e.g., 2 doses of Moderna, Pfizer, or Novavax vaccine, or 1 dose of Janssen vaccine) or any monovalent booster dose at least 2 months ago?			Last dose" ______

Consent: I have read or had explained to me the COVID-19 Emergency Use Authorization and/or the Influenza Vaccine Information Sheet, have had a chance to ask questions, and understand the risks and benefits. I give consent to the Saint Regis Mohawk Health Services staff to administer the vaccine(s) to me. I authorize reporting of my vaccination to NYSIIS for vaccine registry.

Recipient/Guardian Signature: ____ Date: ____________________

AREA BELOW TO BE COMPLETED BY VACCINATOR. WHICH VACCINE IS THE PATIENT RECEIVING TODAY?

MEDICAL RECORD #:	

• COVID-19	• FLU	• **FLU HIGH DOSE**	• INTRANASAL FLUMIST
Lot #: ______________________ Exp: ______________________ Dose: ______________________ VIS Date: __________________	Lot #: ______________________ Exp: ______________________ Dose: ______________________ VIS Date: __________________	Lot #: ______________________ Exp: ______________________ Dose: ______________________ VIS Date: __________________	Lot #: ______________________ Exp: ______________________ Dose: ______________________ VIS Date: __________________
INJECTION SITE	**INJECTION SITE**		• Half dose each nostril
• LEFT DELTOID • RIGHT DELTOID	• LEFT DELTOID	• RIGHT DELTOID	

- I have provided the patient with information about the vaccine(s), and consent for vaccination was obtained.

Nurse Signature: ____ Date: _____________________