

CLINIC CONTRAINDICATION CHECKLIST

Name of Recipient _____ D/O/B _____ M F

- | | Yes | | No |
|--|--------------------------|----|--------------------------|
| 1. Is the child sick with something more than just a cold? | <input type="checkbox"/> | 1 | <input type="checkbox"/> |
| 2. Is the child running a fever? Temperature _____ | <input type="checkbox"/> | 2 | <input type="checkbox"/> |
| 3. Does the child have any type of rash? | <input type="checkbox"/> | 3 | <input type="checkbox"/> |
| 4. Has the child received an immunization within the last six (6) weeks? | <input type="checkbox"/> | 4 | <input type="checkbox"/> |
| 5. Does the child have cancer, leukemia or lymphoma? | <input type="checkbox"/> | 5 | <input type="checkbox"/> |
| 6. Does the child have a disease that lowers the body's resistance to infection? | <input type="checkbox"/> | 6 | <input type="checkbox"/> |
| 7. Is the child taking drugs that lowers the body's resistance to infection, such as cortisone or prednisone. | <input type="checkbox"/> | 7 | <input type="checkbox"/> |
| 8. Does the child live in the same household with anyone who has a condition that lowers the body's resistance to infection? | <input type="checkbox"/> | 8 | <input type="checkbox"/> |
| 9. Is the child pregnant? | <input type="checkbox"/> | 9 | <input type="checkbox"/> |
| 10. Is the child allergic to an antibiotic called neomycin or streptomycin? | <input type="checkbox"/> | 10 | <input type="checkbox"/> |
| 11. Has the child received gamma globulin or a blood transfusion within the preceding five (5) months? | <input type="checkbox"/> | 11 | <input type="checkbox"/> |
| 12. Does the child have convulsions or other neurologic problems, or has a parent, brother or sister ever had a convulsion? | <input type="checkbox"/> | 12 | <input type="checkbox"/> |
| 13. Has the child ever experienced a temperature of 105° or greater after receiving an immunization? | <input type="checkbox"/> | 13 | <input type="checkbox"/> |
| 14. Has the child experienced total collapse (not fainting) or shock following a vaccination? | <input type="checkbox"/> | 14 | <input type="checkbox"/> |
| 15. Has the child ever had persistent screaming episodes of three (3) hours or longer following an immunization? | <input type="checkbox"/> | 15 | <input type="checkbox"/> |
| 16. I am aware and understand the other possible side effects, found on the Important Information forms, that could be caused from the vaccine(s). | <input type="checkbox"/> | 16 | <input type="checkbox"/> |

I have read, understand and have had an opportunity to ask questions concerning the above information and agree to remain in the clinic area for six (6) minutes after the vaccine(s) is/are administered.

Doctor's Name _____

Doctor's Address _____

Parent/Legal Guardian (PRINT) _____

Home Address _____ Phone _____

Parent/Legal Guardian Signature _____ Date _____

If the answer to #16 is no, consult with a nurse before immunizations are given.

SIGNATURE OF NURSE _____