FRANKLIN-WILLIAMSON BI-COUNTY HEALTH DEPARTMENT
Immunization Contraindication Checklist

NAME OF RECIPIENT:_____BIRTHDATE:_____

1.	Does the client have a current Public Aid Medical Card?……...…….	Y	N
	If "Yes", please present current medical card to receptionist.		
2.	Is the client on WIC?…….	Y	N
3.	Is the client sick (with an illness other than a cold)?……..	Y	N
4.	Has client had a fever of over 100° or greater during the last 24 hours?…….. .	Y	N
5.	Has client received an immunization within the last 30 days or a TB skin test within the last 3 days?……	Y	N
6.	Does the client have a disease that lowers the body's resistance to infections, such as leukemia, lymphoma, generalized malignancy or AIDS?……	Y	N
7.	Is client being treated with drugs/medication, such as cortisone or prednisone, chemotherapy or radiation, that lowers the body's resistance to infections?……	Y	N
8.	Does the client live in the same household with anyone who has a condition that lowers the body's resistance to infection?……..	Y	N
9.	Is the client allergic to a gelatin product, streptomycin, neomycin, gentamicin, tobromycin, amikacin, amphotericin B, eggs, yeast, or monosodium glutamate?…….	Y	N
10.	Has client had a blood or plasma transfusion or received immune globulin within the last 5 months?……...	Y	N
11.	Has the client ever had convulsions or other problems of the nervous system?……	Y	N
12.	Is the client pregnant or planning pregnancy within the next 3 months?……..	Y	N
13.	If child is receiving chickenpox vaccine, is there a pregnant household member?……..	Y	N
14.	Has the client ever had a reaction to a previous immunization such as fever greater than 105°, convulsions or seizures, total collapse or shock, a high pitched cry or screaming episode lasting 3 hours or more, severe itching rash or anaphylactic allergic reaction?……...	Y	N
15.	Has the client ever had a serious reaction to a product containing Thimerosal (a mercurial antiseptic)?……	Y	N

I have received, read, and understand the other possible side effects described in the "Vaccine Information Statements" or "Important Information Statements", that could be caused by the vaccine(s). I understand the benefits and risks of the following vaccines and request that it/they be given to me or the person named above for whom I am authorized to make this request.

Signature of Responsible Party:_____Date:_____

Relationship to Recipient:_____
(MUST BE PARENT, LEGAL GUARDIAN, OR CARETAKER IF UNDER 18)

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(OFFICE USE ONLY)

Infant Multi Dose				
DTaP	IPV	HIB	Hep B	PNU-13
TD	Tdap	Varicella	MMR	Rotavirus
HPV	Shingles	Hep A	Meningococcal	MMRV

State ☐ **P/ P** ☐

Nurse reviewing the form
& Administering Vaccine:_____Date:_____

Revised 05/01/2012