Region: _____
Facility Name: _____ Male ☐ Female ☐
Telephone No: Landline: _____ Cell: _____
Patient's name: _____ Date of birth: ____/____/____ Age ____
Address: _____ (day) (mo.) (yr.)

Screening Checklist for Contraindications to Vaccines

Please complete before administering vaccine.

	Yes	No	Don't Know
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4. Have you recently been diagnosed with COVID-19? ?	☐	☐	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
6. In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	☐	☐	☐
7. Do you have a long-term health problem such as heart disease, lung disease, asthma, kidney disease, diabetes, anemia, other blood disorder, seizure or any other nervous system disorder?	☐	☐	☐
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
10. Have you received any vaccinations in the past 4 weeks?	☐	☐	☐

NB: Kindly consult with your Team Leader if the client has answered "Yes" to any of the questions.

Providers Name: …… Signature ……Date ……