Adults OVER 18 Vaccination Form

Form valid for FLU, COVID, RSV, PREVNAR 20

Screening Checklist for Contraindications to Vaccine for Adults

PRINT PATIENT LEGAL NAME: _____

☐ **STAFF MEMBER** ☐ **RESIDENT** **Date of Birth** ____ / ____ / _____

Name of Community: _____

Medicare Number/SSN: _____ *OR attach a copy of Medicare card

What vaccine is the patient receiving today? (check all that apply)

(Check all that apply) ☐ **FLU (Annual)** ☐ **COVID (Annual)** ☐ **RSV (Once over 75)** ☐ **PREVNAR (Once over 50)**

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means that additional questions must be asked. If the question is not clear, please ask your healthcare provider to explain.

	YES	NO	Don't Know
1. Do you have allergies to medicine, food, a vaccine component or latex? Please list:	☐	☐	☐
2. Have you ever had a serious reaction to a vaccine in the past?	☐	☐	☐
3. Do you have any of the following: long-term health problem with heart, lung (including asthma), kidney, liver, nervous system, or metabolic disease (e.g. diabetes), a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak?	☐	☐	☐
4. Are you on long term aspirin therapy?	☐	☐	☐
5. Has the person to be vaccinated ever had Guillain Barre Syndrome?	☐	☐	☐
6. Do you have cancer, leukemia, HIV/AIDS or any other immune system problem?	☐	☐	☐
7. Do you have a parent, brother, or sister with an immune system problem?	☐	☐	☐
8. In the past 6 months, have you taken medications that affected the immune system such as prednisone, other steroids, or anticancer drugs; drugs to treat rheumatoid arthritis, Chron's disease or have you had radiation treatments?	☐	☐	☐
9. Have you had a seizure or brain or other nervous system problems?	☐	☐	☐
10. Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have they had a multisystem inflammatory syndrome (MIS-C) after an infection with the virus that causes COVID-19?	☐	☐	☐
11. In the past year, have you received immune (gamma) globulin, blood/blood products or antiviral drug?	☐	☐	☐
12. Are you pregnant?	☐	☐	☐
13. Have you received vaccinations in the past 4 weeks?	☐	☐	☐
14. Have you ever felt dizzy or faint before, during, or after a shot?	☐	☐	☐
15. Are you anxious about getting a shot today?	☐	☐	☐
16. Is the person to be vaccinated on Hospice? * Medicare does **NOT** cover the vaccination cost while on Hospice. Patient may choose to pay privately.	☐	☐	
17. Are you feeling sick today?	☐	☐	

FORM COMPLETED BY: _____ DATE: _____
Individual, family or provider

FORM REVIEWED BY: _____ DATE: _____
Pharmacy Staff

Label or Lot /Exp

Pharmacy Personnel Only

Deltoid- RD LD

Vaccinator: _____

Date: _____