ST. CLAIR COUNTY HEALTH DEPARTMENT
19 PUBLIC SQUARE, STE 150, BELLEVILLE IL 62220
CLINIC CONTRAINDICATION CHECKLIST

NAME OF CLIENT: _____ DOB: _____ Male Female

CIRCLE YOUR ANSWER

YES NO 1. Is the client sick (with an illness other than a cold)?
YES NO 2. Has the client had a fever of 100 degrees or greater during the last 24 hours?
YES NO 3. Has the client received an immunization within the last thirty (30) days or a TB skin test within the last three (3) days?
YES NO 4. History of Intussusception
YES NO 5. Does the client have a disease that lowers the body's resistance to infections, such as leukemia, lymphoma, generalized malignancy, or HIV?
YES NO 6. Does client have any long-term health problems such as heart or lung disease, asthma or wheezing, kidney or liver disease, diabetes, or anemia or other blood disorders?
YES NO 7. Is client on long-term aspirin treatment?
YES NO 8. Is the client being treated with drugs/medications or therapy, such as cortisone or prednisone, chemotherapy or radiation that lowers the body's resistance to infection?
YES NO 9. Does the client live in the same household with anyone who has a condition that lowers the body's resistance to infection or is there an immediate household contact that has never received OPV?
YES NO 10. Is the client allergic or had a reaction to any of the following: arginine, baker's yeast, eggs, gelatin, gentamycin, latex, MSG, neomycin, streptomycin, or any reaction from any previous vaccination?
YES NO 11. Has the client had a blood or plasma transfusion or received immune globulin within the last six (6) months?
YES NO 12. Has the client ever had convulsions or other muscular or neurologic disorders?
YES NO 13. Has the client ever had a reaction to a previous immunization such as fever greater than 105 degrees, convulsions, total collapse or convulsions, a high-pitched scream or crying episodes lasting three (3) hours or more, severe itching and rash, Guillain-Barre Syndrome, or anaphylactic allergic reaction?
YES NO 14. Does a parent, brother or sister of this client have a history of convulsions/seizures or other neurologic problems?
YES NO 15. Is the client pregnant or planning a pregnancy within the next three (3) months?
YES NO 16. Does the client have hemophilia or any type of clotting disorder?
YES NO 17. Has the client ever had chickenpox or shingles?
YES NO 18. If the client is an infant, did mother test positive for Hepatitis B (surface antigen positive)?

IF THE ANSWER TO ANY OF THE ABOVE QUESTIONS IS "YES", CONSULT WITH THE PHYSICIAN/NURSE BEFORE IMMUNIZATION(S) ARE GIVEN.

I hereby give my consent for lab screening or immunizations for my child.
I have read and understand the possible side effects of immunizations as described in the "Vaccine Information Sheets".

_____ _____
Parent/Legal Guardian Signature Date

Your child's immunization record will be entered into the State of Illinois Data System, I-Care
If you want to opt-out of the State Data System (not have your child's immuinication record seen out at this office)
Your signature is required.

_____ _____
Parent/Legal Guardian Signature Date

Name of Client: _____ **DOB:** _____

FAMILY HISTORY OF CONVULSTIONS/SEIZURES AND OTHER NEUROLOGIC DISORDERS

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1. The recommendation of the Immunization Practices Advisory Committee (ACIP) has concluded that a family history of convulsions in parents, brothers and sisters is not a contraindication to pertussis or measles vaccination.
2. The ACIP recommends that most of the children with a personal or family history of convulsions should receive their pertussis or measles vaccine according to the recommended schedules.
3. The parents/legal guardian of children who have this type of a family history should be advised of the small increased risk (3.2 fold) of seizure following a DPT immunization and the small increased risk following the measles vaccine.
4. Preliminary information suggests that acetaminophen or another NON-ASPIRIN product can reduce fever if given shortly after the DPT and repeated 4 hours later. Clients immunized with measles may experience a fever 1-2 weeks after receiving the vaccine, there it would be prudent to watch for fever and treat with same non-aspirin product if fever occurs.
5. In the unlikely event that a post-immunization seizure does occur, the child's doctor should be notified immediately for direction, and the health department should be informed of the incident.

I have read the above information, and while discussing the possible side effects with the clinic nurse, I have been given educational materials and have had the opportunity to ask questions concerning these matters prior to the administration of the DPT or Measles vaccine.

Parent/Legal Guardian _____ Date _____

*Source: Centers for Disease Control, Morbidity and Mortality Weekly Reports, Atlanta, GA: USDHHS, Vol.36, No. 25, pp 281-282, No. 38/No. S – 9, pp 11-12.

FOR OFFICE USE ONLY

Client contraindication checklist and client immunization record reviewed and the following immunizations are recommended at this visit:

Recommended	Date Administered
Hep. A/ Hep B	_____
DTap/ Tdap/ Td	_____
Hib	_____
Pediarix/Pentacel	_____
Prevnar 13	_____
IPV	_____
MMR	_____
Varicella	_____
Influenza (flu) vaccine	_____
Meningococcal	_____
Rotarix	_____
Gardisal 9(HPV)	_____
Kinrix (Dtap-IPV)	_____
Proquad (MMRV)	_____
Bexsero (Men B)	_____

Vaccine Information Statement (VIS)

- ☐ Varicella (8/06/2021)
- ☐ DTap (8/06/2021)
- ☐ Hepatitis A (10/15/2021)
- ☐ Hepatitis B (10/15/2021)
- ☐ Hib (8/06/2021)
- ☐ HPV (8/06/2021)
- ☐ Influenza (8/06/2021)
- ☐ MMR (8/06/2021)
- ☐ MMRV (8/06/2021)
- ☐ Meningococcal ACWY (8/06/2021)
- ☐ Men. B (8/06/2021)
- ☐ Multi (DTaP, Hib, HBV, IPV, PCV13) (8/06/2021)
- ☐ PCV 13 (8/06/2021)
- ☐ Polio (8/06/2021)
- ☐ Rotavirus (10/15/2021)
- ☐ Tdap (8/06/2021)
- ☐ Td (8/06/2021)

_____ _____

Parent/Legal Guardian **Date**

Name & Title of RN providing vaccination and VIS Education: _____

Date:

Lot Number/Manufacturer Documentation

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