PREVACCINATION SCREENING

Checklist of possible absolute and relative contraindications to vaccination.

This questionnaire needs to be **completed and turned prior to vaccination** and will help your nurse/pediatrician better decide on the timing for today's scheduled vaccination. If you have any questions, please ask your nurse or pediatrician before answering.

Child's name:				
Questionnaire completed by:				
Date:				
	Question	**Yes**	**No**	**?**
1	Is the child sick today?			
2	Is he/she allergic to any medication, food, vaccine or latex?			
3	Has he/she ever had a severe allergic reaction to any vaccine?			
4	Has he/she received any vaccine in the past month?			
5	Has he/she any chronic condition? (diabetes, asthma, heart diseases, coagulation disorder, etc)			
6	Has he/she had seizures, brain problems, or Guillain-Barré syndrome before?			
7	Does he/she have leukemia, cancer or some other disease that affects immunity?			
8	Has he/she received corticosteroids, drugs that decrease immunity or radiotherapy in the last 3 months?			
9	Has he/she received immunoglobulin injections or blood transfusions or other blood derivatives in the last year?			
10	Does he/she live with elderly people or someone with cancer, transplants, or some other circumstance that affects immunity?			
11	In the case of a teenager: is she pregnant or is there a possibility that she could become pregnant in the next 4 weeks?			

Adapted from: Inmmunization Action Coalition.Screening Checklist for Contraindications to Vaccines for Children and Teens (http://www.immunize.org/catg.d/p4060.pdf).

If you have answered "yes" to any of the questions, before vaccination, you should clarify with your nurse or pediatrician if the planned vaccination should be carried out or if an alternative vaccination schedule should be proposed.