SEL HEALTH CLINIC
2560 NE Hopkins Ct
Pullman, WA 99163
509.338.3800

Screening Checklist for Contraindications to Vaccines – Influenza and COVID-19 Event

Patient (Legal) Name: _____

Patient Date of Birth: ____/_____/_____ Patient's Age Today: _____

Phone Number: _____ Premera Insurance Number: SZR-_____

Address: _____ City: _____ State: _____ Zip: _____

Race:
__ American Indian
__ Alaskan Native
__ Asian
__ Black or African American
__ Native Hawaiian or Other Pacific Islander
__ White
__ Other Race

Ethnicity: __ Hispanic __ Not Hispanic

For patients (both children and adults) to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child a vaccination today. Your answers will help us determine if additional questions must be asked. If a question is not clear, please ask your health care provider to explain it.

	Yes	No
1. Is the person to be vaccinated sick today?		
2. Does the person to be vaccinated have an allergy? If yes, please list.		
3. Has the person to be vaccinated had a serious reaction after receiving an immunization in the past?		
4. Has the person to be vaccinated ever had Guillian-Barrĕ Syndrome?		
5. Does the person to be vaccinated have a long-term health problem with lung, heart, kidney or metabolic disease, (e.g. diabetes), asthma, blood disorder, cochlear implant, or spinal fluid leak? Are they on long-term aspirin therapy?		
6. Does the person to be vaccinated have cancer, leukemia, HIV/AIDS, hematopoietic cell transplant (HCT), CAR-T-cell therapies, or other immune system problem?		
7. In the past 6 months, has the person to be vaccinated taken medications that affect your immune system such as: prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?		

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	Yes	No
8. Has the person to be vaccinated had a seizure, brain disorder or other nervous system problem?		
9. Has the person to be vaccinated ever been diagnosed with a heart condition (myocarditis or pericarditis) or had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19?		
10. Has the person to be vaccinated received any vaccination in the past 4 weeks?		
11. In the past year, has the person to be vaccinated received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?		
12. Is the person to be vaccinated Native Alaskan, Native American or have a secondary health insurance?		
13. **For females (assigned at birth):** Is the person to be vaccinated pregnant?		
14. **For children ages 2 through 4 years:** Has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?		
15. **For infants:** Have you ever been told that the child had intussusception?		

COVID-19 VACCINE ONLY	**Yes**	**No**
16. Does the person to be vaccinated have a history of COVID-19 disease within the past three months?		

Form completed by: _____ Today's Date: _____
(Patient or Guardian Signature)

VACCINE NAME:_____ LOT: ☐ VFC EXPIRES: LOCATION: RT DELT LT DELT OTHER _____	**VACCINE NAME:**_____ LOT: ☐ VFC EXPIRES: LOCATION: RT DELT LT DELT OTHER _____
FORM REVIEWED BY PROVIDER INITIALS:	FORM REVIEWED BY PROVIDER INITIALS:
DOCUMENTER INITIALS:	DOCUMENTER INITIALS: