Screening for Influenza Vaccine Contraindications

Save time — have patients fill these out while waiting to be seen

Patient name: _____ Date of birth: ____/____/____ (mo.) (day) (yr.)

Screening Checklist for Contraindications to Inactivated Injectable Influenza Vaccination

For adult patients as well as parents of children to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Don't
1. Is the person to be vaccinated sick today?	
2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine?	
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	
4. Has the person to be vaccinated ever had Guillain-Barré syndrome?	

Form completed by: _____

Form reviewed by: _____

Technical content reviewed by the Centers for Disease Control and Prevention

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These checklists will help you quickly identify contraindications — screen every time you vaccinate!

Patient name: _____ Date of birth: ____/____/____ (mo.) (day) (yr.)

Screening Checklist for Contraindications to Live Attenuated Intranasal Influenza Vaccination

For use with people ages 2 through 49 years: The following questions will help us determine if there is any reason we should not give you or your child live attenuated intranasal influenza vaccine (FluMist) today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Does the person to be vaccinated have an allergy to eggs or to a component of the influenza vaccine?	☐	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to intranasal influenza vaccine (FluMist) in the past?	☐	☐	☐
4. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), or anemia or another blood disorder?	☐	☐	☐
5. If the person to be vaccinated is a child age 2 through 4 years, in the past 12 months, has a healthcare provider ever told you that he or she had wheezing or asthma?	☐	☐	☐
6. Does the person to be vaccinated have cancer, leukemia, HIV/AIDS, or any other immune system problem; or, in the past 3 months, have they taken medications that weaken the immune system, such as cortisone, prednisone, other steroids, or anticancer drugs; or have they had radiation treatments?	☐	☐	☐
7. Is the person to be vaccinated receiving antiviral medications?	☐	☐	☐
8. Is the child or teen to be vaccinated receiving aspirin therapy or aspirin-containing therapy?	☐	☐	☐
9. Is the person to be vaccinated pregnant or could she become pregnant within the next month?	☐	☐	☐
10. Has the person to be vaccinated ever had Guillain-Barré syndrome?	☐	☐	☐
11. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)?	☐	☐	☐
12. Has the person to be vaccinated received any other vaccinations in the past 4 weeks?	☐	☐	☐

Form completed by: _____ Date: _____

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Screening checklist for contraindications to injectable influenza vaccination: www.immunize.org/catg.d/p4066.pdf

Screening checklist for contraindications to intranasal influenza vaccination: www.immunize.org/catg.d/p4067.pdf