

Screening Questionnaire and Consent/Declination Form for Adult Immunization

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 additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

I. Patient Information:		Medicare #:		Social Security #:	
Patient Name:		Allergies:			
Address:		City:	State:	Zip:	
Phone:	DOB:	Age:	Mother's Maiden Name:		
Primary Medical Practitioner:		Vaccination Requested Today:			
Ethnicity: Hispanic or Latino Non-Hispanic or Latino Unknown		Race: White Black/African-American American Indian/Alaska Native Asian Native Hawaiian / Other Pacific Islander Other/Multiple Races Unknown			
II. Vaccination Screening Questionnaire: (Please answer all questions)				Yes	No
1. I decline vaccination at this time.					
2. Is the person to be vaccinated sick today?					
3. Do you have allergies to medications, food, a vaccine component, or latex?					
4. Have you ever had a serious reaction after receiving a vaccine?					
5. Do you have any of the following: long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are you on long term aspirin therapy?					
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 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 have you had radiation treatments?					
9. Have you had a seizure or other nervous system problem?					
10. Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or 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 an antiviral drug?					
12. Are you pregnant?					
13. Have you received any 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?					
Did you bring your immunization record card with you?					
❖ It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.					
III. Patient Consent/Declination of Vaccines:					
I have read, or have had read to me, the Vaccination Information Statement (VIS) regarding the vaccine(s) I am about to receive. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s).					
☐ I consent to, or give consent for, the administration of the vaccine(s) and the notification of my primary care physician. I fully release and discharge their offices, directors and employees from any liability for illness, injury, loss or damage which may result there from. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I understand that I should remain in the pharmacy for 15 minutes for observation in case there is an adverse reaction.					
☐ I decline any vaccinations at this time. I fully understand that I am not protected from the disease processes that the vaccines may protect me from. I understand that the consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact.					
Patient Name (printed): _____					
Patient Signature: _____				Date: _____	
Form reviewed by: _____				Date: _____	

Patient Name:				DOB:			
IV. Immunizations Given Today:							
Vaccine Administration (Pharmacist Use ONLY)							
Vaccine	Dose	Lot#			Exp. Date		
Manufacturer	Injection Site/Route	Left	Right	Deltoid	IM	SQ	
Administered By		VIS Identification			Date of Publication		
Vaccine Administration (Pharmacist Use ONLY)							
Vaccine	Dose	Lot#			Exp. Date		
Manufacturer	Injection Site/Route	Left	Right	Deltoid	IM	SQ	
Administered By		VIS Identification			Date of Publication		
Vaccine Administration (Pharmacist Use ONLY)							
Vaccine	Dose	Lot#			Exp. Date		
Manufacturer	Injection Site/Route	Left	Right	Deltoid	IM	SQ	
Administered By		VIS Identification			Date of Publication		
Did an Adverse Reaction occur? ☐ Yes ☐ No							
Contacted VAERS (https://vaers.hhs.gov/reportevent.html)				Date _____ Time _____			
Primary Medical Practitioner contacted? ☐ Yes ☐ No							
I hereby certify that I have verified the screening questionnaire and consent with the above named patient. Pharmacist Signature: _____ Date: _____							
DID YOU?							
☐ Answer all of the client's concerns and questions ☐ Refer the client to _____ for unavailable immunizations List: _____ ☐ Notify the client's primary care medical practitioner of immunization within 72 hours of administration ☐ Notify your state's IIS registry of the immunization(s) if available							

Source: IAC screening checklists <https://www.immunize.org/wp-content/uploads/catg.d/p4065.pdf>

Information for Health Professionals about the Screening Questionnaire for Adults

Read the information below for help interpreting answers to the screening checklist. To learn more, consult the references in **Note** below.

NOTE: For additional details, see CDC's "Adult Immunization Schedule" (www.cdc.gov/vaccines/hcp/imz-schedules/adult-age.html) and *General Best Practice Guidelines for Immunization* sections on "Contraindications and Precautions" (<http://www.cdc.gov/vaccines/hcp/imz-best-practices/contraindications-precautions.html>) and "Altered Immunocompetence" (<https://www.cdc.gov/vaccines/hcp/imz-best-practices/altered-immunocompetence.html>). For more details on COVID-19 vaccines, see "Use of COVID-19 Vaccines in the United States: Interim Clinical Considerations" at www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html.

2. Are you sick today? [all vaccines]

There is no evidence that acute illness reduces vaccine efficacy or safety. However, as a precaution, all vaccines should be delayed until moderate or severe acute illness has improved. Mild illnesses with or without fever (e.g., otitis media, "colds", or diarrhea) and antibiotic use are NOT contraindications to routine vaccination.

3. Do you have allergies to medications, food, a vaccine component, or latex? [all vaccines]

Gelatin: If a person has anaphylaxis after eating gelatin, do not give vaccines containing gelatin. **Latex:** An anaphylactic reaction to latex is a contraindication to vaccines with latex as part of the vaccine's packaging (e.g., vial stoppers, prefilled syringe plungers, prefilled syringe caps). For details on latex in vaccine packaging, refer to the package insert (listed at www.fda.gov/vaccines-blood-biologics/vaccines/vaccines-licensed-use-united-states).

COVID-19 vaccine: History of a severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a COVID-19 vaccine component is a contraindication to use of the same vaccine type. People may receive the alternative COVID-19 vaccine type (either mRNA or protein subunit) if they have a contraindication or an allergy-related precaution to one COVID-19 vaccine type. Allergy-related precautions include history of 1) diagnosed non-severe allergy to a COVID-19 vaccine component; 2) non-severe, immediate (onset less than 4 hours) allergic reaction after a dose of one COVID-19 vaccine type (see **Note**). **Not contraindications:** Eggs - ACIP and CDC do not consider egg allergy of any severity to be a contraindication or precaution to any egg-based influenza vaccine. **Injection site reaction** (e.g., soreness, redness, delayed-type local-reaction) to a prior dose or vaccine component is not a contraindication to a subsequent dose or vaccine containing that component.

4. Have you ever had a serious reaction after receiving a vaccine? [all vaccines]

Anaphylaxis to a previous vaccine dose or vaccine component is a contraindication for subsequent doses of the vaccine or vaccine component (See question 2). Usually, one defers vaccination when a precaution is present unless the benefit outweighs the risk (e.g., during an outbreak).

5. Do you have any of the following: a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are you on long term aspirin therapy? [MMR, VAR, LAIV]

LAIV is not recommended for people with anatomic or functional asplenia, a cochlear implant, or cerebrospinal fluid (CSF) leak. Underlying health conditions that increase the risk of influenza complications such as heart, lung, kidney, or metabolic disease (e.g., diabetes) and asthma are precautions for LAIV. **MMR:** A history of thrombocytopenia or thrombocytopenic purpura is a precaution to MMR. **VAR:** Aspirin use is a precaution to VAR due to the association of aspirin use, wild type varicella infection, and Reye syndrome in children and adolescents.

6. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? [LAIV, MMR, VAR]

Live virus vaccines are usually contraindicated in immunocompromised people with exceptions. For example, MMR vaccine is recommended and VAR vaccine may be considered for adults with CD4+ T-cell counts of greater than or equal to 200 cells/mcL. See **Note**

7. Do you have a parent, brother, or sister with an immune system problem? [MMR, VAR]

MMR or VAR vaccines should not be administered to a patient with congenital or hereditary immunodeficiency in a first-degree relative (i.e., parent, sibling), unless the patient's immune competence has been verified clinically or by a laboratory.

8. In the past 6 months, have you 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 have you had radiation treatments? [LAIV, MMR, VAR]

Live virus vaccines should be postponed until chemotherapy or long-term high-dose steroid therapy concludes. See **Note**. Some immune mediator and modulator drugs (especially anti-tumor necrosis factor [TNF] agents) may be immunosuppressive. Avoid live virus vaccines in people taking immunosuppressive drugs. A list of such drugs appears in CDC's Yellow Book at: wwwnc.cdc.gov/travel/yellowbook/2024/additional-considerations/immunocompromised-travelers.

9. Have you had a seizure or a brain or other nervous system problem? [influenza, Td/Tdap]

Tdap: Tdap is contraindicated in people with a history of encephalopathy within 7 days following DTP/DTaP. An unstable progressive neurologic problem is a precaution to the use of Tdap. For people with stable neurologic disorders (including seizures) unrelated to vaccination, vaccinate as usual. **A history of Guillain-Barré syndrome (GBS):** 1) **Td/Tdap:** GBS within 6 weeks of a tetanus toxoid-containing vaccine is a precaution; if the decision is made to vaccinate, give Tdap instead of Td; 2) **All Influenza vaccines:** GBS within 6 weeks of an influenza vaccine is a precaution; influenza vaccination should generally be avoided unless the benefits outweigh the risks (e.g., for those at high risk for influenza complications).

10. Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19?

Precautions to COVID-19 vaccination include a history of myocarditis or pericarditis within 3 weeks after a dose of any COVID-19 vaccine or a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A). Myocarditis or pericarditis within 3 weeks after a dose of any COVID-19 vaccine is a precaution: the patient should generally not receive additional COVID-19 vaccine. A person with a history of myocarditis or pericarditis unrelated to vaccination may receive a COVID-19 vaccine once the condition has completely resolved. A person with a history of MIS-C or MIS-A may be vaccinated if the condition has fully resolved and it has been at least 90 days since diagnosis. Refer to CDC COVID-19 vaccine guidance for additional considerations for myocarditis, pericarditis, and MIS (see **Note**).

11. In the past year, have you received immune (gamma) globulin, blood/blood products, or an antiviral drug? [MMR, VAR, LAIV]

See **Note** (schedule) for antiviral drug information (VAR, LAIV). See "Timing and Spacing of Immunobiologics" <https://www.cdc.gov/vaccines/hcp/imz-best-practices/timing-spacing-immunobiologics.html> for intervals between MMR, VAR, and certain blood/blood products, or immune globulin

12. Are you pregnant? [HPV, HepB, IPV, MMR, LAIV, MenB, VAR]

Live virus vaccines (e.g., MMR, VAR, LAIV) are contraindicated in pregnancy due to the theoretical risk of virus transmission to the fetus. People who could become pregnant and receive a live virus vaccine should be instructed to avoid pregnancy for 1 month after vaccination. **IPV and MenB** should not be given except to those with an elevated risk of exposure during pregnancy. **HPV** is not recommended during pregnancy.

13. Have you received any vaccinations in the past 4 weeks?

[LAIV, MMR, VAR, yellow fever]

People given live virus vaccine such as those listed above should wait 28 days before receiving another live virus (wait 30 days for yellow fever vaccine). Inactivated vaccines may be given at the same time or at any spacing interval.

14. Have you ever felt dizzy or faint before, during, or after a shot?

Fainting (syncope) or dizziness is not a contraindication or precaution to vaccination; it may be an anxiety-related response to any injection. CDC recommends vaccine providers consider observing all patients for 15 minutes after vaccination. See Immunize.org's resource on vaccination and syncope at www.immunize.org/catg.d/p4260.pdf.

15. Are you anxious about getting a shot today?

Anxiety can lead to vaccine avoidance. Simple steps can help a patient's anxiety about vaccination. Visit Immunize.org's "Addressing Vaccination Anxiety" clinical resource at www.immunize.org/clinical/topic/addressing-anxiety.

Vaccine Abbreviations:

LAIV = Live attenuated influenza vaccine	cclIV = Cell culture inactivated influenza vaccine
HPV = Human papillomavirus vaccine	HepB = Hepatitis B Vaccine
IIV = Inactivated influenza vaccine	VAR = Varicella vaccine
IPV = Inactivated poliovirus vaccine	MenB = Meningococcal B vaccine
MMR = Measles, mumps, and rubella vaccine	Td/Tdap = Tetanus, diphtheria, (acellular pertussis) vaccine
RIV = Recombinant influenza vaccine	