RUTGERS
New Jersey Medical School

Occupational Medicine Service
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Screening Checklist for Contraindications to Vaccine Administration

Name: _____ DOB (mm/dd/yyyy): _____ Gender: ☐ Male ☐ Female ☐ Other
Primary Telephone #: _____ NetID: _____ Work E-Mail: _____
School / Unit: ☐ CA ☐ NJMS ☐ SDM ☐ SGS ☐ SHP ☐ SN ☐ SPH ☐ UBHC ☐ Other: _____
Department: _____ Job Title: _____

** This information is **CONFIDENTIAL** and will be used for office use **ONLY**. **

QUESTIONS	YES	NO
1. Are you sick today?		
If YES, please specify:		
2. Have you ever had a serious reaction to **any vaccine** (anaphylaxis, Guillain-Barré, etc.)?		
If YES, please specify:		
3. Have you received any other vaccines in the past 4 weeks?		
If YES, please specify:		
4. Do you have allergies to medicine, foods (including eggs), or any vaccine?		
If YES, please specify:		
5. Do you have any immune system problems (cancer, HIV/AIDS, steroid, radiation, or cancer treatment)?		
If YES, please specify:		
6. Have you ever had seizures, brain, or other nervous system problems (including Guillain-Barré)?		
If YES, please specify:		
7. In the **PAST YEAR**, have you received any blood or blood product transfusion and / or immune globulin (IG) treatment for any condition, **INCLUDING** for COVID-19?		
If YES, please specify:		
8. Do you have a history of blood clotting problems or low platelets?		
If YES, please specify:		
9. Are you currently taking antiviral medications or medications that thins the blood?		
If YES, please specify:		
10. Are you pregnant, breastfeeding, or intending to become pregnant?		
If YES, please specify:		

Vaccine(s) You Are Receiving: ☐ Hep A ☐ Hep B ☐ Influenza ☐ MMR ☐ Tdap ☐ Varicella ☐ _____

(VIS) Vaccine Information Statement fact sheet(s) are available for review at: https://www.cdc.gov/vaccines/hcp/vis/current-vis.html.
If you have any questions or concerns regarding this matter, please inquire with a Rutgers University NJMS – OMS vaccine staff member.

Signature: _____ Date of Vaccine: _____

Vaccine Administered By: _____ Date: _____ Time: _____ AM / PM

SITE: ☐ Left Arm ☐ Right Arm	SITE: ☐ Left Arm ☐ Right Arm	☐ Other Site (specify): _____
Vaccine Information Label(s):	Vaccine Information Label(s):	Vaccine Information Label(s):

Provider Notes:

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