RUTGERS
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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: _____

Please answer the following questions. If **YES**, please specify.

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

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

The "Vaccine Information Statement" (VIS) form is available for review at: https://www.cdc.gov/vaccines/hcp/vis/current-vis.html
If you have any questions or concerns, please ask a vaccine staff member.

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

Form Completed By: _____ Date: _____
(Your Signature)

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

Administration Site: ☐ Left Deltoid ☐ Right Deltoid	Vaccine Label(s):

Provider Notes:

_____

_____

☐ Uploaded In Net Health