Tulane LIVING WELL OCCUPATIONAL HEALTH

Vaccine Contraindication Screening for Adults

The following questions will help us determine which vaccines you may be safely given today.

	YES	NO
1. Are you sick today?	☐	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☐
4. Do you have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Are you on long term aspirin therapy?	☐	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐
6. Do you have a parent, brother, or sister with an immune system problem?	☐	☐
7. In the past 3 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?	☐	☐
8. Have you had a seizure or a brain or other nervous system problem?	☐	☐
9. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐
10. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐
11. Have you received any vaccinations in the past 4 weeks?	☐	☐

Employee name:	DOB:
Employee signature:	Date:
Vaccine to be Administered: ☐ Heplisav-B _____of _____ ☐ MMR _____of _____ ☐ Tdap ☐ FLU ☐ Varivax	Site: L / R Deltoid Route: IM / SQ Dose:_____ Lot #:_____ Expiration Date:_____
Occupational Health:	Date: