

# Screening Checklist for Contraindications to Vaccines for Adults 65 yrs and older Consent Form

Name: ..... Date of Birth: .....

The following questions will help us determine if you can receive your vaccine 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.

	yes	no	don't know
1. Are you sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have allergies to medications, food, a vaccine component, or latex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a serious reaction after receiving a vaccination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you had a seizure or a brain or other nervous system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you received any vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Possible Side Effects and Precautions

The flu vaccine is generally well-tolerated.

Like all medicines, vaccines may have side-effects. Some redness, tenderness, discomfort or swelling is common at the injection site, but usually disappears after a few days. (For more information, refer to product information with the vaccine.)

Some people have a mild fever, muscle pains, and generally feel a bit unwell for a few days after the vaccination. These “flu-like” symptoms do not mean you have the flu.

Hives, asthma, and severe allergic reactions occur rarely after the vaccination. If you experience any adverse reaction notify your doctor or seek medical attention immediately.

I have read and understand this information and consent to receiving an influenza vaccine injection. I understand that it is recommended I wait at the immunization center for 15 min after my vaccination. I am in agreement with the administration of the flu vaccination given by the nurse.

I acknowledge all information on this form will be shared with the Wisconsin Immunization Registry (WIR).

It is important for you to have a personal record of your vaccinations. Keep a record in a safe place and bring it with you every time you seek medical care. Make sure your health care provider records all your vaccinations on it.

Recipient SIGNATURE: .....

DATE: .....

Name: Fluad Quadrivalent Influenza 0.5 ml Vaccine

Lot: 312832 Mfg: Seqirus Expiration Date: May 11, 2022

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Clinician SIGNATURE/Title: .....

Insurance Information REQUIRED:

Member Name: \_\_\_\_\_

Insurance Name: \_\_\_\_\_

Member ID: \_\_\_\_\_

Insurance Phone #: \_\_\_\_\_