# CHILDREN AND HOOSIERS IMMUNIZATION REGISTRY PROGRAM (CHIRP)

VACCINE ADMINISTRATION
RECORD OF PARENT/GUARDIAN OR RECIPIENT
SIGNATURE

PATIENT ID

| | | | | |
|---|---|---|---|---|
| Last Name: | First Name: | Middle Name: | Date of Birth: | Age: |
| Alias Last Name: | | Alias First Name: | | |
| Birth State: | Birth Country: | Medicaid #, if applicable: | | Gender: |
| Race: ◯ White ◯ African American ◯ Asian ◯ Multi-Racial ◯ Nat. Hawaiian, Pac Isl. ◯ American Indian ◯ Other | | | Hispanic Origin: ◯ Hispanic ◯ Non-Hispanic ◯ Unknown | |
| Physician Name: | Mother's Maiden Name: | | School: | |
| Guardian 1 Last Name: | First Name: | | Relationship: | |
| Guardian 2 Last Name: | First Name: | | Relationship: | |
| Mailing Address for Responsible Adult: ◯ Mother ◯ Father ◯ Other (specify) _____ | | | | |
| Last Name: | | | First Name: | |
| Address: | | | Home Phone: | Work Phone: |
| City: | State: | Zip: | Email Address: | |
| Language, if other than English (specify): | | | Other Phone (specify): | |
| (CLINIC USE ONLY) | Chart Number: | | | |
| Funding Source ◯ Medicaid ◯ Uninsured ◯ Nat. American or Alaskan ◯ Underinsured ◯ Medicaid Package C - CHIP ◯ Not Eligible/Private Insurance | | | | |

**I authorize the release of any medical or other information necessary to process the claim. I authorize payment of medical benefits to the Health Department responsible for today's service.**

I agree to receive text, voice, and email messages from the Health Department to the phone number(s) and email provided above. Message and data rates may apply.

Signature of person receive vaccine(s) or person authorized to consent to the immunization(s).

_____
*Patient/Parent/Guardian Signature*

_____
*Printed Name*

_____
*Date*

Children & Hoosiers Immunization Registry Program (CHIRP)

Countermeasures Injury Compensation Program (CICP)

**VACCINE ADMINISTRATION**
**PATIENT RECORD**

| Last Name: | First Name: | Middle Name: | Patient ID: |
|---|---|---|---|
| Date of Birth: | Age: | Contraindication: | |
| DO NOT WRITE BELOW THIS LINE - For Clinic Use Only | | | |
| Clinic: | | Date Vaccinated:<br><br>Date VIS Provided to Parent/Guardian/Patient: | |

| Vaccine | Dose | Manufacturer & Lot # | Route/Site | Date of VIS & Date VIS Given |
|---|---|---|---|---|
| DTaP, Tdap, Td | | | | 08/06/21 |
| Hep B | | | | 05/12/23 |
| IPV | | | | 08/06/21 |
| MMR | | | | 08/06/21 |
| Varicella | | | | 08/06/21 |
| HIB | | | | 08/06/21 |
| PCV | | | | PCV 20 05/12/23<br>PPSV 23 10/30/19 |
| Meningococcal | | | | MCV 4 08/06/21<br>MEN B 08/06/21 |
| Influenza | | | | 08/06/21 |
| Hep A | | | | 10/15/21 |
| HPV | | | | 08/06/21 |
| **Rotateq / Rotarix** | | | | 10/15/21 |
| **Vaxelis**<br>DTaP, IPV, HIB, Hep B | | | | 07/24/23 |
| **Pentacel**<br>DTaP, IPV, HIB | | | | 07/24/23 |
| **Pediarix**<br>DTaP, Hep B, IPV | | | | 07/24/23 |
| **Proquad**<br>MMR, Varicella | | | | 07/24/23 |
| **Kinrix**<br>DTaP, IPV | | | | 07/24/23 |
| Other: | | | | |

X _____Signature and Title of Vaccine Administrator

# Screening Checklist for Contraindications to Vaccines for Children and Teens

PATIENT NAME _____

DATE OF BIRTH _____/_____/_____
month day year

**For parents/guardians:** The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child 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.** Is the child sick today? | ☐ | ☐ | ☐ |
| **2.** Does the child have allergies to medicine, food, a vaccine component, or latex? | ☐ | ☐ | ☐ |
| **3.** Has the child had a serious reaction to a vaccine in the past? | ☐ | ☐ | ☐ |
| **4.** Does the child have a long-term health problem with heart, lung (including asthma), kidney, liver, nervous system, or metabolic disease (e.g., diabetes), a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are they taking regular aspirin or salicylate medication? | ☐ | ☐ | ☐ |
| **5.** For children age 2 through 4 years: Has a healthcare provider told you that the child had wheezing or asthma in the past 12 months? | ☐ | ☐ | ☐ |
| **6.** For babies: Have you ever been told the child had intussusception? | ☐ | ☐ | ☐ |
| **7.** Has the child, a sibling, or a parent had a seizure; has the child had a brain or other nervous system problem? | ☐ | ☐ | ☐ |
| **8.** Has the child ever been diagnosed with a heart condition (myocarditis or pericarditis) or have they had Multisystem Inflammatory Syndrome (MIS-C) after an infection with the virus that causes COVID-19? | ☐ | ☐ | ☐ |
| **9.** Does the child have an immune-system problem such as cancer, leukemia, HIV/AIDS? | ☐ | ☐ | ☐ |
| **10.** In the past 6 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs to treat rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments? | ☐ | ☐ | ☐ |
| **11.** Does the child's parent or sibling have an immune system problem? | ☐ | ☐ | ☐ |
| **12.** In the past year, has the child received immune (gamma) globulin, blood/blood products, or an antiviral drug? | ☐ | ☐ | ☐ |
| **13.** Is the child/teen pregnant? | ☐ | ☐ | ☐ |
| **14.** Has the child received vaccinations in the past 4 weeks? | ☐ | ☐ | ☐ |

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

**Did you bring your immunization record card with you?** **yes** ☐ **no** ☐

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.

# Information for Healthcare Professionals about the Screening Checklist for Contraindications to Vaccines (Children and Teens)

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

**NOTE:** For additional details, see CDC's "Child and Adolescent Immunization Schedule" (www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html) and *General Best Practice Guidelines for Immunization* sections on "Contraindications and Precautions" (www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html) and "Altered Immunocompetence" (www.cdc.gov/vaccines/hcp/acip-recs/general-recs/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.

1. **Is the child sick today?** *[all vaccines]*

   There is no evidence that acute illness reduces vaccine effectiveness 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," and diarrhea) and antibiotic use are not contraindications to routine vaccination.

2. **Does the child have allergies to medicine, 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.

3. **Has the child had a serious reaction to a vaccine in the past?** *[all vaccines]*
   - Anaphylaxis to a previous vaccine dose or vaccine component is a contraindication for subsequent doses of corresponding vaccines (see question 2).
   - Usually, one defers vaccination when a precaution is present, unless the benefit outweighs the risk (e.g., during an outbreak).
   - A history of encephalopathy within 7 days of DTP/DTaP is a contraindication for further doses of any pertussis-containing vaccine.
   - Other "serious reactions" that this child experienced following vaccination might constitute contraindications or precautions to future doses. See the appendix on vaccine contraindications and precautions in the **Note** section above.

4. **Does the child have a long-term health problem with heart, lung (including asthma), kidney, liver, nervous system, or metabolic disease (e.g., diabetes), a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are they taking regular aspirin or salicylate medication?** *[MMR, MMRV, LAIV, VAR]*

   **LAIV** is not recommended for children with cerebrospinal fluid leak, anatomic or functional asplenia, cochlear implant, a child age 2 through 4 years with a history of asthma or wheezing, or current aspirin or salicylate-containing medication use. Precautions to LAIV include any underlying health condition that increases the risk of influenza complications (see package insert or CDC schedule for details). **MMR & MMRV:** A history of thrombocytopenia or thrombocytopenic purpura is a precaution to MMR and MMRV. **VAR:** Aspirin use is a precaution to VAR due to the association of aspirin use, chickenpox, and Reye syndrome in children and adolescents.

5. **For children age 2 through 4 years: Has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?** *[LAIV]*

   Children ages 2 through 4 years who had a wheezing episode within the past 12 months should not get LAIV. Give IIV or RIV instead.

6. **For babies: Have you ever been told the child had intussusception?** *[Rotavirus]*

   Infants who have a history of intussusception (i.e., the telescoping of one portion of the intestine into another) should ***not*** be given rotavirus vaccine.

7. **Has the child, a sibling, or a parent had a seizure; has the child had a brain or other nervous system problem?** *[DTaP, Td, Tdap, IIV, LAIV, MMRV, RIV]*

   For patients with stable neurologic disorders (including seizures) unrelated to vaccination, or with a family history of seizures, vaccinate as usual (exception: children with a first degree relative [e.g., parent or sibling] or personal history of seizures generally should receive separate MMR and VAR, not MMRV). **Pertussis-containing vaccines:** DTaP and Tdap are contraindicated in children who have a history of encephalopathy within 7 days following DTP/DTaP. An unstable progressive neurologic problem is a precaution to using DTaP and Tdap. **A history of Guillain-Barré syndrome (GBS):** a) Td/Tdap: GBS within 6 weeks of a tetanus-toxoid vaccine is a precaution; if the decision is made to vaccinate, give Tdap instead of Td; b) 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 higher risk for influenza complications).

8. **Has the child ever been diagnosed with a heart condition (myocarditis or pericarditis) or have they had Multisystem Inflammatory Syndrome (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). Myocarditis or pericarditis within 3 weeks after a dose of any COVID-19 vacine is a precaution: the person should generally not receive additional COVID-19 vaccine. A child with a history of myocarditis or pericarditis unrelated to vaccination may receive a COVID-19 vaccine once the condition has completely resolved. A child with a history of MIS-C 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**).

9. **Does the child have an immune-system problem, such as cancer, leukemia, HIV/AIDS?** *[LAIV, MMR, MMRV, Rotavirus, VAR]*

   Live virus vaccines are usually contraindicated in immunocompromised people with exceptions. For example, **MMR** is recommended for asymptomatic HIV-infected patients who are not severely immunosuppressed. **VAR** should be administered (if indicated) to people with isolated humoral immunodeficiency. **LAIV** is contraindicated in immunosuppressed people; give IIV or RIV instead. Infants with severe combined immunodeficiency (SCID) should not be given a live virus vaccine, including **rotavirus vaccine**, but other forms of immunosuppression are a precaution, not a contraindication, to rotavirus vaccine. See "General Best Practice Guidelines: Altered Immunocompetence" at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html.

10. **In the past 6 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs to treat rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?** *[LAIV, MMR, MMRV, VAR]*

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

11. **Does the child's parent or sibling have an immune system problem?** *[MMR, MMRV, VAR]*

    MMR, MMRV, and VAR vaccines should **not** be given to a patient with a family history of congenital or hereditary immunodeficiency in first-degree relatives (e.g., parents, siblings) unless the patient's immune competence has been verified clinically or by a laboratory.

12. **In the past year, has the child received immune (gamma) globulin, blood/blood products, or an antiviral drug?** *[MMR, MMRV, LAIV, VAR]*

    See **Note** (schedule) for antiviral drug information (VAR, LAIV). See "Timing and Spacing of Immunobiologics" (www.cdc.gov/vaccines/hcp/acip-recs/general-recs/timing.html#antibody) for intervals between MMR, VAR, and certain blood/blood products, immune globulin.

13. **Is the child/teen pregnant?** *[HPV, IPV, LAIV, MenB, MMR, MMRV, VAR]*

    **Live virus vaccines** (e.g., LAIV, MMR, MMRV, VAR) 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. **HepB:** Heplisav-B and PreHevbrio are not recommended during pregnancy, use Engerix-B or Recombivax-HB. **HPV** is not recommended during pregnancy.

14. **Has the child received vaccinations in the past 4 weeks?** *[LAIV, MMR, MMRV, VAR, yellow fever]*

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

15. **Has the child 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.

16. **Is the child anxious about getting a shot today?**

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

**VACCINE ABBREVIATIONS**

DTaP = Diphtheria, tetanus, & acellular pertussis vaccine
HPV = Human papillomavirus vaccine
IIV = Inactivated influenza vaccine
ccIIV - cell culture inactivated influenza vaccine
IPV = Inactivated poliovirus vaccine
LAIV = Live attenuated influenza vaccine
MenB = Meningococcal B vaccine
MMR = Measles, mumps, and rubella vaccine
MMRV = MMR+VAR vaccine
RIV = Recombinant influenza vaccine
Td, Tdap = Tetanus, diphtheria, (acellular pertussis) vaccine
VAR = Varicella vaccine

# Washington County Health Department
# Acknowledgment of Notice of Privacy Practices

*My signature below indicates that I have been given an opportunity to read and or be given a copy of the Notice of Privacy Practices for the Washington County Health Department, and to have any questions answered prior to signing.*

_____ _____

***Signature*** ***Date***

***If signed by someone other than the person receiving services, please indicate Relationship to the patient:***

☐ *Parent or guardian of a minor patient.*
☐ *Guardian or conservator of an incompetent patient*
☐ *Beneficiary or person representative of deceased patient.*

_____

***For Office Use Only:***

_____ _____

***Employee Signature*** ***Date***

***If a patient representative refuses to sign this acknowledgment:***

☐ *Efforts to obtain:* _____

☐ *Reason for Refusal:* _____