

Screening Checklist for Contraindications to Live Attenuated Intranasal Influenza Vaccination

PATIENT NAME _____

DATE OF BIRTH _____ / _____ / _____
month day year

For use with people age 2 through 49 years: The following questions will help us determine if there is any reason we should not give you or your child live attenuated intranasal influenza vaccine (FluMist) today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your health care provider to explain it.

| | yes | no | don't know |
|--|--------------------------|--------------------------|--------------------------|
| 1. Is the person to be vaccinated sick today? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does the person to be vaccinated have an allergy to eggs or to a component of the influenza vaccine? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Is the person to be vaccinated younger than age 2 years or older than age 49 years? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease (including asthma), kidney disease, neurologic disease, liver disease, disease (e.g., diabetes), or anemia or another blood disorder? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. If the person to be vaccinated is a child age 2 through 4 years, in the past 12 months, has a health care provider told you the child had wheezing or asthma? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Does the person to be vaccinated have cancer, leukemia, HIV/AIDS, or any other immune system problem; or, in the past 3 months, have they taken medications that affect the immune system, such as prednisone, other steroids, drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis or anticancer drugs; or have they had radiation treatments? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Is the person to be vaccinated receiving influenza antiviral medications? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Is the person to be vaccinated a child or teen age 2 through 17 years and receiving aspirin therapy or aspirin-containing therapy? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Is the person to be vaccinated pregnant or could she become pregnant within the next month? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has the person to be vaccinated ever had Guillain-Barré syndrome? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Has the person to be vaccinated received any other vaccinations in the past 4 weeks? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

