CLAY COUNTY HEALTH DEPARTMENT
IMMUNIZATION INTAKE / CONTRAINDICATION CHECKLIST

Please complete the following information about the person to receive the vaccine(s) and/or test(s).

Last Name:		**First Name**		**M.I.**			
Date of Birth		**Age**		**Gender:**	**Male Female**	**Phone #**	
Address		**City**		**IL**	**Zip**		
Primary Physician		**Mother's Maiden Name**					

1.	Is client enrolled in ☐ Medicaid	Y	N
2.	Is client an American Indian or Alaska Native?	Y	N
3.	Does client have **private Health Insurance** that covers immunizations (ex. BC/BS, Healthlink, TriCare, Coventry, etc.)? **If yes, what is the Policyholder Name and Date of Birth** _____	Y	N
4.	Is the client sick with an illness other than a cold? If yes, what does the client have?	Y	N
5.	Has client had a fever of 100 degrees or greater during the last 24 hours?	Y	N
6.	Has client received an immunization within the last 4 weeks or a TB skin test with the last 3 days?	Y	N
7.	Does the client have a disease that lowers the body's resistance to infections, such as leukemia, lymphoma, generalized malignancy, AIDS, cancer, or any other immune system problem?	Y	N
8.	Is the client being treated with drugs, such as cortisone, prednisone, or other steroid, chemotherapy, radiation, or any anticancer drug which lowers the body's resistant to infections? *Has the child received treatment in the past 3 months?	Y	N
9.	Does client have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia or other blood disorder; is he or she on long-term aspirin therapy?	Y	N
10.	Is the client allergic to Thimerosal, Alum, neomycin, eggs or yeast (swelling of the mouth or throat, difficulty in breathing, shock); any allergies to medication, food, or vaccine component or latex?	Y	N
11.	Has the client had a blood or plasma transfusion or received an antiviral drug or immune globulin within the last year?	Y	N
12.	Has the client ever had convulsions (seizures) or other neurological (brain) problems? *Has child, sibling or parent?	Y	N
13.	Has the client ever had a reaction to a previous immunization such as: a fever greater than 105 degrees, convulsions, total collapse or shock, a high pitched crying or screaming for 3 hours or more, severe itching rash or anaphylactic allergic reaction?	Y	N
14.	Does the client have a rash?	Y	N
15.	If the child to be vaccinated is between ages 2-4 years, has the healthcare provider told you that the child had wheezing or asthma within the past 12 months?	Y	N
16.	If your child is a baby, have you ever been told he or she has had intussusceptions? (bowel obstruction)	Y	N
17.	If client is female, is she pregnant or planning pregnancy within the next month?	Y	N
18.	I have been given an opportunity to read the Notice Of Privacy Practices for the Clay County Health Department, and to have any questions answered. ***Please initial acknowledgement in the box to the right.***		

If the answer to any of the above health questions is "yes" consult with the nurse before receiving immunizations.

I understand that I will have a chance to ask questions regarding the vaccine(s) and/or test(s) and that the benefits and risks of the vaccine(s) and/or test(s) will be explained to me, and given to me on the "Vaccine Information Sheet(s). I also give consent for the vaccine(s) and/or test(s) to be given to me or the person named above, for whom I am authorized to make the request. I further authorize payment directly to Clay County Health Department (CCHD) for services rendered and I authorize CCHD to share the immunization record of the person named above with their physician and school as requested. **I also give my consent to have my immunization data entered into the State of Illinois Electronic Medical Record system called I-Care.**

I Provided and Reviewed the Vaccine Information / Reaction Sheet with the Client/ Guardian

Client or Guardian Signature **Date**

RN's Signature **Date**