Practice: _____

Address: _____

_____

Phone: _____

Fax: _____

Date: _____/_____/_____

Pre-vaccination screening checklist

This checklist helps decide about vaccinating you or your child today. Please fill in the following information for your doctor/nurse.

Name of person to be vaccinated: _____

Date of birth: _____

Age today: _____

Name of person completing this form: _____

Please indicate if the person to be vaccinated:

□ is unwell today

□ has a disease that lowers immunity (e.g. leukaemia, cancer, HIV/AIDS) or is having treatment that lowers immunity (e.g. oral steroid medicines such as cortisone and prednisone, radiotherapy, chemotherapy)

□ is an infant of a mother who was receiving highly immunosuppressive therapy (e.g. biological disease modifying anti-rheumatic drugs (bDMARDs) during pregnancy

□ has had a severe reaction following any vaccine

□ has *any* severe allergies (to anything)

□ has had any vaccine in the past month

□ has had an injection of immunoglobulin, or received any blood products or a whole blood transfusion within the past year

□ is pregnant

□has a past history of Guillain-Barré syndrome

□ was a preterm infant

□ has a chronic illness

□ has a bleeding disorder

□identifies as an Aboriginal or Torres Strait Islander

□ does not have a functioning spleen

□ is planning a pregnancy or anticipating parenthood

□ is a parent, grandparent or carer of a newborn

□ lives with someone who has a disease that lowers immunity (e.g. leukaemia, cancer, HIV/AIDS), or lives with someone who is having treatment that lowers immunity (e.g. oral steroid medicines such as cortisone and prednisone, radiotherapy, chemotherapy)

□ is planning travel

□ has an occupation or lifestyle factor(s) for which vaccination may be needed (discuss with doctor/nurse)

Please specify:

Signature of patient or carer: _____

Name of patient or carer: _____