

**CHILDREN AND HOOSIER IMMUNIZATION REGISTRY PROGRAM  
(CHIRP) VACCINE ADMINISTRATION  
RECORD OF PARENT/GUARDIAN OR RECEIPT SIGNATURE**

I have read or had explained to me the information in the 'Vaccine information statement(s)' or the "Important Information Statement(s)" for the disease(s) and vaccine(s) checked below. I have had a chance to ask questions and fully understand the benefits and risks of the vaccine(s) checked below. I request that these vaccines be given to me or to the person named below.

- |                               |   |                              |  |                                    |  |                                 |
|-------------------------------|---|------------------------------|--|------------------------------------|--|---------------------------------|
| <input type="checkbox"/> Td   | <input type="checkbox"/> DTaP/IPV           | <input type="checkbox"/> RSV | <input type="checkbox"/> Influenza .50ml | <input type="checkbox"/> MMR       | <input type="checkbox"/> HEP B         | <input type="checkbox"/> PCV 20 |
| <input type="checkbox"/> Tdap | <input type="checkbox"/> DTaP/IPV/Hep B     | <input type="checkbox"/> IPV | <input type="checkbox"/> COVID-19        | <input type="checkbox"/> MMRV      | <input type="checkbox"/> HEP B (adult) | <input type="checkbox"/> PCV 15 |
| <input type="checkbox"/> DTaP | <input type="checkbox"/> DTaP/IPV/HiB       | <input type="checkbox"/> HiB | <input type="checkbox"/> Flu Mist        | <input type="checkbox"/> Varicella | <input type="checkbox"/> HEP A         | <input type="checkbox"/> PCV 13 |
|                               | <input type="checkbox"/> DTaP/IPV/HiB/Hep B |                              | <input type="checkbox"/> High Dose       | <input type="checkbox"/> Zoster    | <input type="checkbox"/> HEP A (adult) | <input type="checkbox"/> PPSV23 |
|                               |   |                              | <input type="checkbox"/> HPV 9V          | <input type="checkbox"/> Rotavirus | <input type="checkbox"/> MCV 4         | <input type="checkbox"/> Men B  |

Last Name:		First Name:		Middle:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other
Date of Birth:	Age:	Birth State:	Birth Country:	Hoosier Healthwise #:	
Race: <input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> Nat. Hawaiian, Pac Islander <input type="checkbox"/> American Indian			Hispanic Origin: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown		
Physician Name:			School District Reside In:		
Guardian 1 Last Name:		First Name:		Relationship: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other	
Guardian 2 Last Name:		First Name:		Mother Maiden Name:	
<b>Mailing Address</b>					
Address:		Home Phone:		Work Phone:	
City:	State:	ZIP Code:	Email Address:		
Language, if other than English (specify):			Other Contact Phone (specify):		
<b>Clinic Use Only:</b> <input type="checkbox"/> Medicaid <input type="checkbox"/> Uninsured <input type="checkbox"/> Nat. American or Alaskan					
Funding Source: <input type="checkbox"/> Underinsured – FQHC or RHC Only <input type="checkbox"/> Hoosier Hwise Pkg C <input type="checkbox"/> Ineligible <input type="checkbox"/> 317					

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

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

\_\_\_\_\_  
Parent/Guardian/Patient Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

Children & Hoosiers Immunization  
Registry Program (CHIRP)

Countermeasures Injury  
Compensation Program (CICP)





Lake County Indiana – Health Department

2900 West 93rd Ave. Crown Point, IN 46307

**CLINIC USE ONLY**

*Note any vaccine refusals next to vaccine name*

Vaccine	VIS	MANUFACTURER/LOT #	VIS GIVEN	INJECTION SITE		ROUTE
Dtap	8/6/21			L arm L thigh	R arm R thigh	IM
Dtap/IPV	8/6/21			L arm L thigh	R arm R thigh	IM
Dtap/Hep B/IPV	7/24/23			L arm L thigh	R arm R thigh	IM
Dtap/Hib/IPV	7/24/23			L arm L thigh	R arm R thigh	IM
Dtap/IPV/Hib/Hep B	7/24/23			L arm L thigh	R arm R thigh	IM
Hep A adult    pediatric	10/15/21			L arm L thigh	R arm R thigh	IM
Hep B adult    pediatric	5/12/23			L arm L thigh	R arm R thigh	IM
Hib	8/6/21			L arm L thigh	R arm R thigh	IM
HPV	8/6/21			L arm	R arm	IM
Influenza	8/6/21			L arm L thigh	R arm R thigh	IM
MCV4	8/6/21			L arm	R arm	IM
Men B	8/6/21			L arm	R arm	IM
MMR	8/6/21			L arm L thigh	R arm R thigh	SC
MMRV	8/6/21			L arm L thigh	R arm R thigh	SC
Pneumococcal	5/12/23			L arm	R arm	IM
PPSV 23	10/30/19			L thigh	R thigh	
Polio	8/6/21			L arm L thigh	R arm R thigh	IM SC
Rotavirus	10/15/21					PO
RSV antibody	9/25/23			L arm	R arm	IM
RSV	10/17/24					
Tdap	8/6/21			L arm	R arm	IM
Varicella	8/6/21			L arm L thigh	R arm R thigh	SC
Zoster	2/4/22			L arm	R arm	IM
Covid-19	10/17/24			L arm	R arm	IM

VACCINATOR NAME AND CREDENTIALS:

DATE:

Checked out in third party biller on:

Initials:



# 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the child have allergies to medicine, food, a vaccine component, or latex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the child had a serious reaction to a vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. For babies: Have you ever been told the child had intussusception?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has the child, a sibling, or a parent had a seizure; has the child had a brain or other nervous system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Does the child have an immune-system problem such as cancer, leukemia, HIV/AIDS?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Does the child's parent or sibling have an immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. In the past year, has the child received immune (gamma) globulin, blood/blood products, or an antiviral drug?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Is the child/teen pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Has the child received vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Has the child ever felt dizzy or faint before, during, or after a shot?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Is the child anxious about getting a shot today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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](http://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](http://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](http://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](http://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](http://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 vaccine 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](http://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 [www.wnc.cdc.gov/travel/yellowbook/2024/additional-considerations/immunocompromised-travelers](http://www.wnc.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](http://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:** HepB: HepB: HepB and PreHepBrio 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](http://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/](http://www.immunize.org/clinical/topic/addressing-anxiety/)

### VACCINE ABBREVIATIONS

DTaP = Diphtheria, tetanus, & acellular pertussis vaccine  
HPV = Human papillomavirus vaccine  
IIV = Inactivated influenza vaccine  
cIIV - 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