

Patient name: _____ Date of birth: ____/____/____
 (mo.) (day) (yr.)

Screening Checklist for Contraindications to Live Attenuated Intranasal Influenza Vaccination

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 healthcare 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, metabolic 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 healthcare 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 weaken the immune system, such as cortisone, prednisone, other steroids, 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 child or teen (2 years through 17 years of age) to be vaccinated 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: _____ | | |

Technical content reviewed by the Centers for Disease Control and Prevention