Table 2.1.1: Pre-vaccination screening checklist

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)

☐ 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:_____