

# OCCUPATIONAL HEALTH SCREENING FORM

**Reason for Visit:**

**Date:**

| Patient Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                        |         |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|---------|
| Name                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |             | DOB                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | DoD ID or Full SSN:    |         |
| Organization/Program                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Job Title & Job Series |         |
| Work Number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |             | Cell Number:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                        |         |
| Email:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Supervisor: |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Supervisor's Phone:    |         |
| Personal medical history (check all that apply)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                        |         |
| <input type="checkbox"/> No known medical conditions<br><input type="checkbox"/> Allergies (Drug, Food, Environmental)<br><input type="checkbox"/> Anemia<br><input type="checkbox"/> Anxiety<br><input type="checkbox"/> Arthritis<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Autoimmune Disorder (Specify: _____)<br><input type="checkbox"/> Cancer (Specify: _____)<br><input type="checkbox"/> Congestive heart failure<br><input type="checkbox"/> COPD / Emphysema<br><input type="checkbox"/> Depression<br><input type="checkbox"/> Diabetes (Type 1 / Type 2)<br><input type="checkbox"/> Epilepsy / Seizures<br><input type="checkbox"/> GERD (Acid Reflux)<br><input type="checkbox"/> Glaucoma<br><input type="checkbox"/> Gout |             | <input type="checkbox"/> Heart Attack / Heart Disease<br><input type="checkbox"/> High Blood Pressure (Hypertension)<br><input type="checkbox"/> High Cholesterol<br><input type="checkbox"/> HIV/AIDS<br><input type="checkbox"/> Kidney Disease / Kidney Stones<br><input type="checkbox"/> Liver Disease / Hepatitis<br><input type="checkbox"/> Migraines<br><input type="checkbox"/> Osteoporosis<br><input type="checkbox"/> Sleep Apnea<br><input type="checkbox"/> Sleep: Insomnia/Difficulties<br><input type="checkbox"/> Stroke<br><input type="checkbox"/> Substance Abuse (Alcohol / Drugs)<br><input type="checkbox"/> Thyroid Disease (Hypo / Hyper)<br><input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> Ulcers |                        |         |
| Other medical issues:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                        |         |
| Medications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                        |         |
| Name(s)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Dosage(s)   | Frequency                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Reason for Taking      | Note(s) |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                        |         |
| Medication Allergies/Reaction    Name of Medication(s):<br><input type="checkbox"/> No medication allergies    Reaction(s):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                        |         |
| Allergy to Latex:    Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, reaction:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                        |         |

| Surgeries (site and date)                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                       |                                                    |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                       |                                                    |
| Social history                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                       |                                                    |
| Factor                                                                                                                                                                                                                                                                                                                          | Check one                                                                                                                                                                                             | Most recent date<br><small>(if applicable)</small> |
| Tobacco Use                                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Chew/Dip <input type="checkbox"/> Vape <input type="checkbox"/> Quit <input type="checkbox"/> Never Used |                                                    |
| Alcohol Use                                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/> Occasional <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy <input type="checkbox"/> Don't Drink                                                             |                                                    |
| Caffeine (Coffee, Tea, Soda, Energy Drinks)                                                                                                                                                                                                                                                                                     | <input type="checkbox"/> No <input type="checkbox"/> Yes (amount per day)                                                                                                                             |                                                    |
| Pre/Post Workout Supplements                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> No <input type="checkbox"/> Yes [   ] Times per week                                                                                                                         |                                                    |
| Exercise Routine                                                                                                                                                                                                                                                                                                                | [   ] Times per week                                                                                                                                                                                  |                                                    |
| Sleep                                                                                                                                                                                                                                                                                                                           | [   ] Hours a night                                                                                                                                                                                   |                                                    |
| Living Situation: <input type="checkbox"/> With roommates <input type="checkbox"/> With S/O <input type="checkbox"/> With family <input type="checkbox"/> Other:                                                                                                                                                                |                                                                                                                                                                                                       |                                                    |
| <b>Additional Notes</b><br><br><br><br><br><br><br><br><br><br><p><i>By providing my name (full name: first and last), date of birth (DOB) and today's date, I hereby certify that, to the best of my knowledge, the above provided information is true and accurate.</i></p> <p>Patient name: _____ DOB: _____ Date: _____</p> |                                                                                                                                                                                                       |                                                    |
| <b>Staff Section:</b><br><br>Vitals:<br>Height: _____ Weight: _____ BMI: _____<br><br>BP: _____ HR: _____ Resp: _____ Temp: _____ O2Sat: _____<br><br>Repeat vitals:<br><br><br>Nurses Notes:<br><br><br><br><br><br><br><br><br><br>Providers Notes:                                                                           |                                                                                                                                                                                                       |                                                    |

## AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

## PRIVACY ACT STATEMENT

**AUTHORITY:** Public Law 104-191, Health Insurance Portability and Accountability Act of 1996; 10 U.S.C. Chapter 55, Medical and Dental Care; DoD Manual (DoDM) 6025.18, Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs; and E.O. 9397 (SSN).

**PRINCIPAL PURPOSE(S):** DD Form 2870 collects patient data and a patient's, or their parent's or legal representative's, authorization for a military treatment facility or dental treatment facility or DoD health plan to use or disclose an individual's protected health information.

**ROUTINE USE(S):** To third parties or individuals as per your written authorization.

**APPLICABLE SORN:** EDHA 07, Military Health Information System (June 15, 2020; 85 FR 36190). <https://dpclid.defense.gov/Portals/49/Documents/Privacy/SORNS/DHA/EDHA-07.pdf>

**DISCLOSURE:** Voluntary. If you choose not to provide your information, no penalty may be imposed and there will be a non-release of the protected health information. This form will not be used for authorization to disclose substance abuse information or treatment, if any, within your medical records nor will it be used to authorize the use or disclosure of psychotherapy notes, if any, within your medical records.

## SECTION I - PATIENT DATA

|                                              |                                                                                                                                                 |                           |
|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|
| 1. NAME (Last, First, Middle Initial)        | 2. DATE OF BIRTH (YYYYMMDD)                                                                                                                     | 3. SOCIAL SECURITY NUMBER |
| 4. PERIOD OF TREATMENT: FROM - TO (YYYYMMDD) | 5. TYPE OF TREATMENT (X one)<br><input type="checkbox"/> BOTH <input type="checkbox"/> INPATIENT <input checked="" type="checkbox"/> OUTPATIENT |                           |

## SECTION II - DISCLOSURE

|                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                    |                                       |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|---------------------------------------|
| 6. I AUTHORIZE Fox Army Health Center Occupational Health Clinic<br>(Name of Facility/TRICARE Health Plan)                                                                                                                                                                                                                                                                                                                                           |                                                                                                                    | TO RELEASE MY PATIENT INFORMATION TO: |
| a. NAME OF PERSON OR ORGANIZATION TO RECEIVE MY MEDICAL INFORMATION<br>Hiring civilian Personnel Agency/Human Resources and/or Supervisory Personnel                                                                                                                                                                                                                                                                                                 | b. ADDRESS (Street, City, State and ZIP Code)<br>4100 Goss Road<br>Redstone Arsenal, AL 35809-7000                 |                                       |
| c. TELEPHONE (Include Area Code)                                                                                                                                                                                                                                                                                                                                                                                                                     | d. FAX (Include Area Code)                                                                                         |                                       |
| 7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION (X as applicable)<br><input type="checkbox"/> PERSONAL USE <input type="checkbox"/> CONTINUED MEDICAL CARE <input type="checkbox"/> SCHOOL <input checked="" type="checkbox"/> OTHER (Specify) Pre-placement, Fit for duty, Medical qualification or Medical Surveillance exams<br><input type="checkbox"/> INSURANCE <input type="checkbox"/> RETIREMENT/SEPARATION <input type="checkbox"/> LEGAL |                                                                                                                    |                                       |
| 8. INFORMATION TO BE RELEASED<br>Copies of physical examination and supporting documentation (i.e. labs, test results, etc) related to physical and mental evaluation for physical year from authorization start date to authorization expiration date.                                                                                                                                                                                              |                                                                                                                    |                                       |
| 9. AUTHORIZATION START DATE (YYYYMMDD)                                                                                                                                                                                                                                                                                                                                                                                                               | 10. AUTHORIZATION EXPIRATION<br><input type="checkbox"/> DATE (YYYYMMDD) <input type="checkbox"/> ACTION COMPLETED |                                       |

## SECTION III - RELEASE AUTHORIZATION

I understand that:

a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.

b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR 164.524.ss

d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.

I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

|                                                      |                                                |                     |
|------------------------------------------------------|------------------------------------------------|---------------------|
| 11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE | 12. RELATIONSHIP TO PATIENT<br>(If applicable) | 13. DATE (YYYYMMDD) |
|------------------------------------------------------|------------------------------------------------|---------------------|

## SECTION IV - FOR STAFF USE ONLY (To be completed only upon receipt of written revocation)

|                                                                                                                   |                             |                                                                                           |
|-------------------------------------------------------------------------------------------------------------------|-----------------------------|-------------------------------------------------------------------------------------------|
| 14. X IF APPLICABLE:<br><input type="checkbox"/> AUTHORIZATION REVOKED                                            | 15. REVOCATION COMPLETED BY | 16. DATE (YYYYMMDD)                                                                       |
| 17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE<br>Last name, First name:<br>DOB:<br>DoD ID#:<br>Date: |                             | SPONSOR NAME:<br>SPONSOR RANK:<br>FMP/SPONSOR SSN:<br>BRANCH OF SERVICE:<br>PHONE NUMBER: |

# HEALTH CARE WORKER TUBERCULOSIS (TB) RISK ASSESSMENT TOOL

For use of this form see, MEDCOM Reg 40-64, the proponent agency is MCPO-SA

| Health Care Worker Tuberculosis (TB) Risk Assessment Tool                                                                                                                                                                                        |                                                          | REVIEWER INSTRUCTION                                                                                                                                                                                                    |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Do you have any of the following TB symptoms: cough >2 Weeks, fever >2 weeks, drenching night sweats, or unexplained weight loss?                                                                                                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                                                                                                                                         |
| <b>If "YES" → STOP.</b><br><b>If "NO" → Go to question #2</b>                                                                                                                                                                                    |                                                          | <b>If "YES" then refer immediately to provider for evaluation of TB disease.</b>                                                                                                                                        |
| 2. Do you work in an emergency room, inpatient hospital setting, primary care clinic, mycobacteriology laboratory, or other health setting where TB patients are evaluated or treated.                                                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                                                                                                                                         |
| <b>If "NO" → STOP.</b><br><b>If "YES" → Go to question #3</b>                                                                                                                                                                                    |                                                          | <b>If "NO" then do not test.</b>                                                                                                                                                                                        |
| 3. Do you have written documentation of a prior positive TB test, prior diagnosis of TB, or prior treatment for TB?                                                                                                                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                                                                                                                                         |
| <b>If "YES" → STOP.</b><br><b>If "NO" → Go to question #4</b>                                                                                                                                                                                    |                                                          | <b>If "YES" then do NOT test.</b>                                                                                                                                                                                       |
| 4. Is this your first TB evaluation at this health care facility?                                                                                                                                                                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                                                                                                                                         |
| <b>If "YES" → STOP.</b><br><b>If "NO" → Go to question #5</b>                                                                                                                                                                                    |                                                          | <b>If "YES" then perform two-step TB skin testing.</b>                                                                                                                                                                  |
| 5. Since your last TB risk assessment, did you have face-to-face contact with someone who was sick with tuberculosis (TB)?<br><br>If yes, nature of exposure: Household – Co-worker – Family –<br><br>Other _____<br><br>Dates of exposure _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Indicate the Health Care Facility's current TB risk Classification:<br><br><input type="checkbox"/> Low Risk<br><br><input type="checkbox"/> Medium Risk<br><br><input type="checkbox"/> Potential ongoing transmission |
| <b>Reviewer comments</b>                                                                                                                                                                                                                         |                                                          |                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                                                  |                                                          | <b>If "YES" then test.</b><br><b>If "NO" then test only if at a medium or high risk facility</b>                                                                                                                        |
| <b>PATIENT'S IDENTIFICATION (For typed or written entries give: Name-last-first-middle; DOB; SSN; date; hospital or medical facility)</b><br><br>NAME:<br>DOB:<br>DoD ID #:<br>DATE:                                                             | <b>REVIEWER NAME</b>                                     | <b>REVIEWER SIGNATURE</b>                                                                                                                                                                                               |
|                                                                                                                                                                                                                                                  |                                                          |                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                                                  |                                                          |                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                                                  |                                                          |                                                                                                                                                                                                                         |

## Routine Immunization Screening Form: Adult

*NOTE: If cholera or smallpox vaccines are being considered, please complete their respective immunization screening forms.*

|                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|-------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>AUTHORITY:</b>       | 10 U.S.C. 1071-1085, Medical and Dental Care; Army Regulation 40-562, Immunizations and Chemoprophylaxis for the Prevention of Infectious Disease; DoDM 6025.18, Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>PURPOSE:</b>         | To determine whether you can safely receive a routine immunization.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>ROUTINE USES:</b>    | Use and disclosure of your records outside of DoD may occur in accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a(b)). Collected information may be shared with entities including the Departments of Health and Human Services, Veterans Affairs, and other Federal, State, local, or foreign government agencies, or authorized private business entities.<br><br>To appropriate agencies, entities, and persons when (1) the DoD suspects or has confirmed that there has been a breach of the system of records; (2) the DoD has determined that as a result of the suspected or confirmed breach there is a risk of harm to individuals, the DoD (including its information systems, programs, and operations), the Federal Government, or national security; and (3) the disclosure made to such agencies, entities, and persons is reasonably necessary to assist in connection with the DoD's efforts to respond to the suspected or confirmed breach or to prevent, minimize, or remedy such harm. |
| <b>APPLICABLE SORN:</b> | EDHA 07, Military Health Information System (November 18, 2013, 78 FR 69076) <a href="https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570672/edha-07/">https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570672/edha-07/</a>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>DISCLOSURE:</b>      | Voluntary. If you choose not to provide the requested information, no penalty may be imposed; however, failure to provide the information may result in delays in assessing contraindications for receiving vaccinations.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

Patient name:

DOB (YYYYMMDD):

### Screening Checklist for Contraindications to Vaccines for Adults

**For patients:** The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you 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.  | Are you sick today?                                                                                                                                                                                                                                                       | <input type="checkbox"/>                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2.  | Have you ever had a serious reaction after receiving a vaccination?                                                                                                                                                                                                       | <input type="checkbox"/>                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3.  | Do you have allergies to medication, food, a vaccine component, or latex?                                                                                                                                                                                                 | <input type="checkbox"/>                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.  | Have you had a seizure or a brain or other nervous system problem?                                                                                                                                                                                                        | <input type="checkbox"/>                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5.  | Have you had a health problem involving heart, lung (e.g., asthma), kidney, or metabolic disease (e.g., diabetes), anemia, or other blood disorder?                                                                                                                       | <input type="checkbox"/>                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6.  | Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?                                                                                                                                                                                               | <input type="checkbox"/>                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7.  | In the past 3 months, have you taken medications that weaken your immune system, such as prednisone or other steroids; anticancer drugs; biologic drugs for autoimmune diseases such as rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments? | <input type="checkbox"/>                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8.  | In the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?                                                                                                                                 | <input type="checkbox"/>                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9.  | Have you had (or are you a candidate for) your spleen removed, or do you have sickle cell anemia?                                                                                                                                                                         | <input type="checkbox"/>                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | Have you ever passed out (had vasovagal syncope) during or after a previous immunization or blood draw?                                                                                                                                                                   | <input type="checkbox"/>                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. | Have you received any vaccinations in the past 4 weeks?                                                                                                                                                                                                                   | <input type="checkbox"/>                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. | Are you pregnant or is there a chance you could become pregnant during the next month?                                                                                                                                                                                    | Not Applicable<br><input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Please list any medications you are currently taking:

Form completed by:

Date (YYYYMMDD):

Form reviewed by:

Date (YYYYMMDD):

Did you bring your immunization record/card with you?

Yes ☐ No ☐

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it. For questions or concerns regarding immunizations, providers, nurses and patients may call the DHA Immunization Healthcare Support Center 24/7 at 1-877-438-8222, Option 1.

## Information for Healthcare Professionals about the Screening Checklist for Contraindications (Adult)

Each screening question is explained in more detail below. For more information, please consult the sources referenced at the end.

### 1. Are you sick today? [all vaccines]

There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events.<sup>1</sup> However, as a precaution with moderate or severe acute illness, all vaccines should be delayed until the illness has improved. Mild illnesses (such as otitis media, upper respiratory infections, and diarrhea) are NOT contraindications to vaccination. Do not withhold vaccination if a person is taking antibiotics.

### 2. Have you ever had a serious reaction after receiving a vaccination? [all vaccines]

History of anaphylactic reaction (see question 3) to a previous dose of vaccine or vaccine component is a contraindication for subsequent doses.<sup>1</sup> History of encephalopathy within 7 days following DTP/DTaP is a contraindication for further doses of pertussis-containing vaccine. There are other adverse events that may occur following vaccination that constitute contraindications or precautions to future doses. Under normal circumstances, vaccines are deferred when a precaution is present. However, situations may arise when the benefit outweighs the risk (e.g., during a community pertussis outbreak).

### 3. Do you have allergies to medications, food, a vaccine component, or latex? [all vaccines]

An anaphylactic reaction to latex is a contraindication to vaccines that contain latex as a component or as part of the packaging (e.g., vial stoppers, prefilled syringe plungers or caps). If a person has anaphylaxis after eating gelatin, do not administer vaccines containing gelatin. For patients with known Alpha-gal syndrome (red meat allergy), caution should be exercised with gelatin-containing vaccines (i.e. MMR, VAR, YF-Vax), as some of these patients have demonstrated anaphylaxis with these vaccines. A local reaction to a prior vaccine dose or vaccine component, including latex, is not a contraindication to a subsequent dose or vaccine containing that component.<sup>2,3</sup> People with egg allergy of any severity can receive any recommended influenza vaccine (i.e., any IIV or RIV) that is otherwise appropriate for the patient's age. For people with a history of severe allergic reaction to egg involving any symptom other than hives (e.g., angioedema, respiratory distress), or who required epinephrine or another emergency medical intervention, the vaccine should be administered in a medical setting, such as a clinic, health department, or physician's office. Vaccine administration should be supervised by a healthcare provider who is able to recognize and manage severe allergic conditions.<sup>4</sup>

### 4. Have you had a seizure, or had brain or other nervous system problems?

[IIV, LAIV, Td, Tdap]

Tdap is contraindicated in patients who have a history of encephalopathy within 7 days following DTP/DTaP given as a child. An unstable, progressive neurologic condition is a precaution to the use of Tdap. For patients with stable neurologic disorders (including seizures) unrelated to vaccination, or for patients with a family history of seizures, vaccinate as usual. A history of Guillain-Barre syndrome (GBS) is a precaution for the following: 1) Td/Tdap: if GBS occurred within 6 weeks of a tetanus-containing vaccine and the decision is made to continue vaccination, if no history of prior Tdap, give Tdap instead of Td; 2) Influenza vaccine (IIV or LAIV): if GBS occurred within 6 weeks of a prior influenza vaccination, vaccinate with IIV if at high risk for severe influenza complications.

### 5. Have you had a health problem involving heart, lung (e.g., asthma), kidney, or metabolic disease (e.g., diabetes), anemia, or other blood disorder? [MMR, LAIV, SPV]

A history of thrombocytopenia or thrombocytopenic purpura is a precaution to MMR vaccine. The safety of LAIV in patients with these conditions has not been established. These conditions, including asthma in adults, should be considered precautions for LAIV use.

### 6. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?

[Adenovirus, Cholera, LAIV, MMR, SPV, Ty21a, VAR, YF-Vax, ZVL]

Live virus vaccines are usually contraindicated in immunocompromised patients; however, there are exceptions. MMR is recommended and varicella should be considered for adults with CD4+ T-lymphocyte counts of greater than or equal to 200cell/ $\mu$ L. Immunosuppressed patients should not receive LAIV. For details, consult current ACIP recommendations.<sup>1,6,7,8</sup>

### 7. In the past 3 months, have you taken medications that weaken your immune system, such as prednisone or other steroids; anticancer drugs; biologic drugs for autoimmune diseases such as rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments? [Adenovirus, Cholera, MMR, SPV, Ty21a, VAR, YF-Vax, ZVL]

Live virus vaccines should be postponed until after chemotherapy or long-term, high-dose steroid therapy has ended. For details and length of time to postpone, consult the current ACIP statement.<sup>1</sup> Some immune mediator and immune modulator drugs (especially the antitumor necrosis factor agents adalimumab, infliximab, and etanercept) may be immunosuppressive. The use of live vaccines should be avoided in persons taking these drugs.<sup>1</sup> Specific vaccination schedules for stem cell transplant (bone marrow transplant) patients can be found on the NIH website.<sup>8</sup> LAIV, when recommended, can be given only to healthy, non-pregnant people ages 2 through 49 years.

### 8. In the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?

[MMR, VAR]

Certain live virus vaccines may need to be deferred, depending on several variables. Consult the most current ACIP recommendations for information on intervals between receipt of antiviral drugs, immune globulin or blood products, and live virus vaccines.<sup>1,7</sup>

### 9. Have you had (or are you a candidate for) your spleen removed, or do you have sickle cell anemia? [Hib, LAIV, PCV13, PPSV23, MCV4, MenB]

Patients with anatomic or functional asplenia (i.e. sickle-cell disease) are at an increased risk of certain vaccine preventable diseases to include Haemophilus influenzae type b, meningococcal, and pneumococcal disease. LAIV is not recommended for people with anatomic or functional asplenia. Hib, PCV13, MCV4, and MenB vaccine should be given 14 days before splenectomy, if possible. Doses given during the 14 days prior to surgery can be counted as valid. Doses that cannot be given prior to surgery should be given as soon as the patient's condition has stabilized after surgery. For patients 2 years of age and up: the first dose of PPSV23 should be administered 8 weeks after the last dose of PCV13. A second dose of PPSV23 should be administered 5 years after the first dose. A third, final dose of PPSV23 should be administered after age 65 years, if both previous doses were before the age of 65.

### 10. Have you ever passed out (had vasovagal syncope) during or after a previous immunization or blood draw? [all vaccines]

Providers should be aware of the potential for syncope (fainting) associated with vaccination, particularly among adolescents. Appropriate measures should be taken to prevent syncope, and to readily respond to the patient who feels faint. Observe all patients for 15 minutes after vaccination for signs and symptoms that precede syncope, such as weakness, dizziness, sweatiness, and pallor. For patients prone to syncope, make sure they are either seated or lying down at the time of vaccination. (If the patient is seated during vaccination, the immunizer should be seated as well, to minimize the risk of SIRVA). If a patient becomes pre-syncope, have them lie flat or sit with head between knees for several minutes; loosen any tight clothing and maintain an open airway; apply cool, damp cloths to the patient's face and neck. Observe the patient until symptoms completely resolve.

### 11. Have you received any vaccinations in the past 4 weeks? [LAIV, MMR, SPV, VAR, YF-Vax, ZVL]

Patients who were given either LAIV, SPV, or an injectable live virus vaccine should wait 28 days before receiving another live vaccine. Inactivated vaccines may be given at the same time or at any spacing interval.

### 12. Are you pregnant, or is there a chance you could become pregnant during the next month? [Adenovirus, HPV, IPV, MMR, LAIV, VAR, SPV, Ty21a, possibly YF-Vax, ZVL]

Live virus vaccines are contraindicated one month before and during pregnancy because of the theoretical risk of virus transmission to the fetus. Sexually active women who receive a live virus vaccine should be instructed to practice careful contraception for one month following receipt.<sup>6,9</sup> On theoretical grounds, HPV and IPV should not be given during pregnancy; however, IPV may be given if risk of exposure is imminent (e.g., travel to endemic areas). Inactivated influenza vaccine and Tdap are both recommended during pregnancy. Both vaccines may be given at any time during pregnancy, but the preferred time for Tdap administration is at 27-36 weeks gestation.<sup>10</sup>

1. ACIP General Best Practice Guidelines for Immunization: [www.cdc.gov/vaccines/hcp/acip-recs/general-recs/downloads/general-recs.pdf](http://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/downloads/general-recs.pdf).  
2. Latex in Vaccine Packaging: [www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/latexable.pdf](http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/latexable.pdf).  
3. Table of Vaccine Components: [www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/exipient-table-2.pdf](http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/exipient-table-2.pdf).  
4. Prevention and control of seasonal influenza with vaccines: Recommendations of the Advisory Committee on Immunization Practices. [www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/flu.html](http://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/flu.html).  
5. Measles, mumps, and rubella-vaccine use and strategies for elimination of measles, rubella, and congenital rubella syndrome and control of mumps. MMWR 1998, 47(RR-8).  
6. Prevention of varicella: Recommendations of the Advisory Committee on Immunization Practices. MMWR 2007, 56(RR-4).

7. Rubin L.G., Levin M.J., Ljungman P. (2014) IDSA Clinical practice guideline for vaccination of the immunocompromised host. *Clinical Infectious Diseases*, 58(3), 309–318  
8. Tomblyn M, Einsele H, et al. 2009. Guidelines for preventing infectious complications among hematopoietic stem cell transplant recipients: a global perspective. *Biology of Blood and Marrow Transplant* 15:1143-1238.  
9. Revised ACIP recommendation for avoiding pregnancy after receiving a rubella-containing vaccine. MMWR 2001; 50(49).  
10. Updated recommendations for use of tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine (Tdap) in pregnant women: ACIP. MMWR 2012 62(07):131-135.

#### Vaccine Abbreviations:

- Hib: *Haemophilus influenza* type b
- HPV: human papillomavirus
- IIV: inactivated influenza
- IPV: inactivated poliovirus
- LAIV: live attenuated influenza
- MCV4: meningococcal conjugate, quadrivalent, serogroups A, C, W, Y
- MenB: meningococcal serogroup B
- MMR: measles, mumps, rubella
- PPSV23: pneumococcal polysaccharide (23-valent)
- RIV: recombinant influenza
- SIRVA: shoulder injury related to vaccine administration
- SPV: vaccinia (smallpox)
- Td: tetanus/diphtheria toxoids
- Tdap: tetanus toxoid, reduced diphtheria toxoid, acellular pertussis
- Ty21a: oral typhoid
- VAR: varicella
- YF-Vax: yellow fever
- ZVL: zoster vaccine live