CLAY COUNTY HEALTH DEPARTMENT
IMMUNIZATION INTAKE / CONTRAINDICATION CHECKLIST

Please complete the following information about the person to receive the vaccine(s) and/or test(s).

Last Name:		**First Name**		**M.I.**			
Date of Birth		**Age**		**Gender:**	**Male Female**	**Phone #**	
Address		**City**		**IL**	**Zip**		
Primary Physician		**Maiden or Previous Last Name (s)**					

1.	Does client have **Private Health Insurance** that covers immunizations (ex. BC/BS, Healthlink, TriCare, Coventry, etc.)? **If yes, what is the Policyholder Name and Date of Birth** _____	Y	N
2.	Is client enrolled in Medicaid/AllKids?	Y	N
3.	Is client an American Indian or Alaska Native?	Y	N
4.	Has client received an immunization within the last 4 weeks or a TB skin test within the last 3 days?	Y	N
5.	Is the client sick with an illness other than a cold, or had a fever of 100 degrees or more in the past 24 hours?	Y	N
6.	Has client had any severe allergic reactions to Thimerosal, Alum, neomycin, eggs or yeast, or any other vaccine components? If yes, to what and type of reaction?	Y	N
7.	Does the client have a disease that lowers the body's resistance to infections, such as leukemia, lymphoma, generalized malignancy, AIDS, cancer, or any other immune system problem, or are or in the past three months been receiving a treatment that may affect the body's resistance such as: Prednisone, Cortisone, other steroid, chemotherapy, or radiation? If yes, specifics:	Y	N
8.	Does client have a long-term health problem such as heart, lung kidney or metabolic disease, asthma, anemia, or other blood disorder; and/or is he or she on long-term aspirin therapy? If yes, specifics:	Y	N
9.	Has the client ever had convulsions (seizures) or other neurological (brain) problems? Has sibling or parent? If yes, whom and when:	Y	N
10.	Does the client have a rash?	Y	N
11.	If client is female, is she pregnant or planning pregnancy within the next month?	Y	N
12.	I have been given an opportunity to read the Notice Of Privacy Practices for the Clay County Health Department, and to have any questions answered. ***Please initial acknowledgement in the box to the right.***		

If the answer to any of the above health questions is "yes" consult with the nurse before receiving immunizations.

I understand that I will have a chance to ask questions regarding the vaccine(s) and/or test(s) and that the benefits and risks of the vaccine(s) and/or test(s) will be explained to me, and given to me on the "Vaccine Information Sheet(s). I also give consent for the vaccine(s) and/or test(s) to be given to me or the person named above, for whom I am authorized to make the request. I further authorize payment directly to Clay County Health Department (CCHD) for services rendered and I authorize CCHD to share the immunization record of the person named above with their physician and school as requested. **I also give my consent to have my immunization data entered into the State of Illinois Electronic Medical Record system called I-Care.**

I Provided and Reviewed the Vaccine Information / Reaction Sheet with the Client/ Guardian

Client or Guardian Signature **Date**

RN's Signature **Date**

FOR NURSE(S) USE ONLY

Vaccine

	DTaP – Diphtheria, Tetanus, acellular Pertussis (08-06-21) - (Dapatacel or Infanrix)
	Hepatitis A - (01-31-25)
	Hepatitis B - (HBV – 01-31-25)
	Hib – Haemophilus B conjugate (08-06-21) – (Pedvax)
	HPV – Human Papillomavirus– (08-06-21)
	Influenza – (01-31-2025)
	IPV – Inactivated Polio Vaccine (01-31/25)
	Kinrix - (DTaP 08-06-21), (IPV 01-31-25)
	MenB (01-31-25)
	Meningococcal Vaccine – (01-31-25) - MCV4/MPSV4
	MMR – Measles, Mumps, Rubella (01-31-25)
	Multiple Vaccines (DTaP, Hib, HepB, Polio, PCV13 (07-24-23)
	Pediarix - (DTaP-08-06-21), (Polio-01-31-25) & (HepB-01-31-25)
	Prevnar 20 (PCV20) pneumococcal conjugate (05-12-23)
	Proquad – Measles, Mumps, Rubella, & Varicella (MMRV 01-31-25)
	Rabies – (06-02-22)
	Rotavirus - (10-15-21)
	RSV – (01-31-25)
	RSV antibody IIS (09-25-23)
	Shingrix- (02-04-22)
	Tdap – (01-31-25) –(Boostrix)
	Tuberculin Skin Test
	Typhoid (10-30-19)
	Varicella - (01-31-25) – Varivax (Chicken Pox)

Labs

	Hemoglobin Test	Results
	Lead Screen (Fingerstick or Venipuncture)	

Revised: 04/11/2025