Appointment Date _____ **Appt. Time** _____/#_____

Vaccines for Children (VFC) Program—Patient Eligibility Screening Record

Please complete the highlighted section below. Please print clearly.

Child's Name: _____
First Name MI Last Name

Child's Date of Birth: _____/_____/_____ Age: _____ E-Mail: _____

Parent Name: _____ Phone #: _____

Address: _____
Street City State Zip

Please check the following category that best describes your child:

□**Underinsured** □**No Health Insurance** □**Native Alaskan/American Indian** □**Medicaid Plan/#** _____

1) Has your child or anyone in your household been diagnosed with COVID-19? □ YES □NO If so, when? _____

2) Has your child or anyone in your household had symptoms of COVID-19 with or without a test in the past 14 days? □YES □NO (fever, chills, cough, shortness of breath, fatigue, muscle aches, headaches, new loss of taste or smell, sore throat, nasal congestion, nausea, vomiting, diarrhea, pink eye, rashes, or red/swollen toes)

For Office Use: Clinic Day Screening Date: _____ Status: _____ Temperature: Adult ____°F Child: ____°F

Health and Human Services has implemented a 24-hour cancellation policy for each patient scheduled. As a reminder, if you cancel, change or miss your scheduled appointment with less than 24-hour notice, we reserve the right to charge a $25.00 out-of-pocket fee.

I have read and agree with the cancellation policy. _____ _____
Signature Date

Place Copy of Insurance Card Here

FOR OFFICE USE ONLY	Eligible for VFC Vaccine				Not eligible for VFC Vaccine		
	A	B	C	D	E	F	G
	Medicaid Enrolled Title XIX (19) V02	No Health Insurance (V03)	American Indian or Alaskan Native (V04)	*Underinsured at FQHC, RHC or deputized LHD only (V05)	Has health insurance that covers vaccines (V01)	** Other underinsured (V01)	***Enrolled in CHIP/Medicaid Title XXI (21) or State Funded (V22)
Date/Initial							

*Underinsured includes children with health insurance that does not cover vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance.

****Children who are enrolled in separate state Children's Health Insurance Program (CHIP) with Medicaid Title XXI (21) or State Funded coverage are considered insured and are not eligible for vaccines through the VFC program.**

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?	☐	☐	☐
2. Does the child have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Does the child have a long-term health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Is he/she on long-term aspirin therapy?	☐	☐	☐
5. If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐	☐	☐
6. If your child is a baby, have you ever been told he or she has had intussusception?	☐	☐	☐
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐	☐	☐
8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
9. Does the child have a parent, brother, or sister with an immune system problems?	☐	☐	☐
10. In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	☐	☐	☐
11. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
12. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐	☐
13. Has the child received vaccinations in the past 4 weeks?	☐	☐	☐
14. Has your child previously received 2 or more doses of seasonal flu vaccine?	☐	☐	☐
15. Has your child had or does he/she currently have a neurological condition called Guillain-Barre Syndrome?	☐	☐	☐
16. Has your child received a Tdap, DTaP or Prevnar vaccine recently*? If YES when? _____	☐	☐	☐

Notes: Please notify nurse if your child is allergic to: Chicken products—egg albumins/proteins, chicken feathers or dander, Formaldehyde, Gelatin, Octoxynol-10/Octylphenol Ethoxylate (Triton X-100), Sodium phosphate-buffered isotonic sodium chloride solution, Thimerosal, Sodium Deoxycholate, a-Tocopheryl Hydrogen Succinate, Polysorbate 80, Gentamicin, or Hydrocortisone.

***One study has shown that there may be decreased effectiveness of the Pertussis (Whooping Cough) components of Tdap Vaccine when given within 4 weeks of the Flu Shot. There is an increased risk for seizure caused by high fevers when Prevnar Vaccine and/or DTaP Vaccine and the Flu Shot are given together. I have received and read or have had explained to me the Inactivated Influenza Vaccine Information Statement Sheet (08/07/15) about the vaccine that will be administered.**

Form Completed By: **X**_____ Date: _____

Form Reviewed By: _____ Date: _____