

Patient Name: _____ Date of Birth ____/____/____

Child/Adolescent Immunization Screening Questionnaire

Fayette County Health Department, 416 W Edwards St., Vandalia, IL 62471, 618-283-1044

The following questions 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 information may be asked. Please ask any questions to your healthcare provider to explain it.

The following questions apply to the person receiving the immunization: Yes No Unsure

1	Is the child sick today?			
2	Does the child have allergies to medication, food, a vaccine component, or latex?			
3	Has the child had a serious reaction to a vaccine in the past?			
4	Has the child had a health problem with lung, heart, kidney, metabolic disease (e.g diabetes) asthma or a blood disorder? Is he/she on long-term aspirin therapy?			
5	If the child is between the ages of 2 and 4 years old, has a Healthcare Provider told you that the child had wheezing or asthma in the past 12 months?			
6	Has the child, a sibling, or a parent had a seizure, brain, or nerve problem?			
7	Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?			
8	In the past 3 months, has the child taken medication that weakens their immune system, such as cortisone, prednisone, other steroids, or anti-cancer drugs, or had radiation treatments?			
9	Has the patient received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug in the past year?			
10	If female, is the patient pregnant or is there a chance the patient could become pregnant during the next month?			
11	Has the patient received vaccinations in the past 4 weeks?			
12	If your child is a baby, have you ever been told he/she has had intussusception?			

If receiving the HPV vaccine, it is recommended client stays in office for 15 minutes after receiving vaccine. _____ initials

I have received VIS forms. I know the risks and I give permission to administer immunizations.

Parent/Guardian Signature: _____ Physician: _____

Pedarix	Tdap/Td	Rotavirus	Hep A	MMR	Kinrix	HPV	Flu/Flu Mist
VIS 5/17/07 11/8/11, 2/2/12	VIS 2/24/15 2/24/15	VIS 4/15/15	VIS 10/25/11	VIS 4/20/12	VIS 5/1/07 11/8/11	VIS 4/15/15 5/17/13	VIS 8/19/14

Prevnar13	Menactra	HIB	Dtap	Varicella	MMRV	Polio	
VIS 2/27/13	VIS 10/14/11	VIS 4/2/15	VIS 5/17/07	VIS 3/13/08	VIS 5/21/10	VIS 11/8/11	

Nurse's Signature

Date Vaccine Administered

Vaccines for Children (VFC) Program Patient Eligibility Screening Record

A record of all children 18 years of age or younger who receive immunizations must be kept in the health care provider's office for 3 years or longer depending on state law. The record may be completed by the parent, guardian, individual of record, or by the health care provider. VFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure the child's eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine. Providers using a similar form (paper-based or electronic) must capture all reporting elements included in this form.

1. Child's Name : _____

Last Name
First Name
MI

2. Child's Date of Birth: ____/____/____

3. Parent/Guardian/Individual of Record: _____

Last Name
First Name
MI

4. Primary Provider's Name: _____

Last Name
First Name
MI

5. To determine if a child (0 through 18 years of age) is eligible to receive federal vaccine through the VFC and state programs, at each immunization encounter/visit enter the date and mark the appropriate eligibility category. *If Column A-D is marked, the child is eligible for the VFC program. If column E, F or G is marked the child is not eligible for federal VFC vaccine.*

Date	Eligible for VFC Vaccine				Not Eligible for VFC Vaccine		
	A Medicaid Enrolled	B No Health Insurance	C American Indian or Alaskan Native	D *Underinsured served by FQHC, RHC or deputized provider	E Has health insurance that covers vaccines	F **Other underinsured	G ***Enrolled in CHIP

**Underinsured includes children with health insurance that does not include vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance. In addition, to receive VFC vaccine, underinsured children must be vaccinated through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) or under an approved deputized provider. The deputized provider must have a written agreement with an FQHC/RHC and the state/bca territorial immunization program in order to vaccinate underinsured children.*

*** Other underinsured are children that are underinsured but are not eligible to receive federal vaccine through the VFC program because the provider or facility is not a FQHC/RHC or a deputized provider. However, these children may be served if vaccines are provided by the state program to cover these non-VFC eligible children.*

****Children enrolled in separate state Children's Health Insurance Program (CHIP). These children are considered insured and are not eligible for vaccines through the VFC program. Each state provides specific guidance on how CHIP vaccine is purchased and administered through participating providers. CHIP (All Kids) recipients are eligible for vaccines purchased by the State and distributed by the Illinois Vaccines for Children (VFC) program to providers enrolled in the VFC program.*