PCHD Patient Eligibility Screening Record & Consent

A screening record must be kept at the local public health agency that reflects the status of all clients who receive vaccine through the VFC Program or other state funded vaccine. The parent, guardian or individual of record, or the health care provider may complete the record.

Child's Name: _____ Date of Birth: _____

Parent/Guardian: _____ Child's Age: _____

Address: _____ Phone: _____

VFC Eligibility

a. Is enrolled in MOHealthNet (state insurance).
   - Home State Health
   - United Health Care
   - Healthy Blue

If so, what is your number _____

b. Does not have health insurance
c. Is American Indian or Alaskan Native
d. Has other privately purchased health insurance? (Either through work, private policy, military, etc.)

Private Insurance – *Please attach a copy of your child's card.*

Carrier: _____ Cardholder Name: _____

Policy #: _____ Cardholder DOB: _____

Cardholder Address: _____

Screening Questionnaire for Child & Teen Immunizations

For parents/guardians: The following questions will help us determine which vaccines may be given today. If a question is not clear, please ask the nurse to explain it.

	No	Yes
Is the child sick today? (Fever, not wanting to eat, green mucus, irritable, lethargic, etc)		
Does the child have allergies to medication, latex, food or any vaccine?		
Has the child had a serious reaction a vaccine in the past?		
Has the child had a seizure, brain, or other nervous system problems?		
For females: Is your child pregnant?		

Consent

I have been given a copy and have read, or had explained to me, the information in the "Vaccine Information Statement(s) for the vaccine(s) indicated below. I have had a chance to ask questions and have them answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) currently due for which I have signed below, be given to me or the person named above for whom I am authorized pursuant to Section 431.058 to make this request. I acknowledge by my signature below, that I have been offered a copy of Putnam County Health Department's "Notice of Privacy Practice Act (HIPAA)".

I give consent for my child to receive:

Required

__ **TDaP** (Tetanus, Diphtheria & Pertussis)
__ **MenQuafi** (Meningitis)

Recommended

__ **Gardasil** (Human Papillomavirus)

Parent/Guardian Signature: _____ Date: _____