

Please print or type

Illinois Department of Public Health
Patient Eligibility Screening Record
Vaccines for Children (VFC) Plus Program

Date: _____

Child: _____
Last Name First Name MI

Date of Birth: _____

Parent/Guardian
Individual of Record: _____
Last Name First Name MI

Provider: _____ Lee County Health Department

A record must be kept in the health care provider's office that reflects the status of all children 18 years or younger, who receive immunization through the VFC Plus Program. The record may be completed by the parent, guardian or individual of record, or by the health care provider. This same record may be used for all subsequent visits as long as 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.

The parent or guardian has stated that this child qualifies for vaccination through the federal Vaccines For Children (VFC) program because he or she (check only one box):

- (a) Is enrolled in Medicaid (Public Aid Card)
- (b) Does not have health insurance
- (c) Is American Indian or Alaskan Native

OR this child does not qualify for vaccination through the Vaccines For Children (VFC) program (unless the provider is a Federally Qualified Health Center or Rural Health Clinic); however, this child may be provided vaccine through the Illinois Vaccines for Children (VFC) Plus Program because he or she:

- (d) Has health insurance that does not pay for vaccines (underinsured).

The above eligibility status information was provided by me to my child's health care provider.

X _____
Signature of Parent or Legal Guardian Relationship Date

Printed by Authority of the State of Illinois
P.O. #515144 10M 09/94 IL 482-0893

Please check any that apply:

Enrolled in Family Case Management Program

****Information about Person to Receive Vaccine (Please Print)****

Name: Last: _____ First: _____ MI: _____

Address: _____ Birthdate: _____ Age: _____

City: _____ State: _____ Zip Code: _____

"I have been given a copy and have read or have had explained to me the information in the Vaccine Information Statement about the vaccine(s) that will be administered. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) be given to me or to the person named above for whom I am authorized to make this request." (Vaccine Information Statements: DTaP - 5/17/07; Td/Tdap - 01/24/2012; Polio - 11/08/2011; HepB - 02/02/2012; MMR - 3/13/08; Hib - 12/16/98; Varicella - 3/13/08; PCV13 - 4/16/10; Meningococcal - 10/14/11; HepA - 10/25/11; Rotavirus - 12/6/10; HPV Gardasil - 3/30/10; MMRV - 5/21/10; HepB/Polio/PCV/DTaP/Rotavirus/Hib - 9/18/08).

Signature of person to receive vaccine or person authorized to make the request (parent or guardian): _____ Date: _____

FOR OFFICE/CLINIC USE ONLY **Revised 02/2012**

Clinic/Office Address: LEE COUNTY HEALTH DEPARTMENT • 309 South Galena, Suite 100 • Dixon, IL 61021

Signature of Vaccine Administrator: _____ Title: RN

<p>DTaP <input type="checkbox"/> Td <input type="checkbox"/> Tdap <input type="checkbox"/></p> <p style="padding-left: 100px;">A <input type="checkbox"/> B <input type="checkbox"/></p> <p>Date Administered: _____</p> <p>Manuf/Lot# _____ EXP: _____</p> <p>Site: <u>IM</u></p>	<p>MMR <input type="checkbox"/> MMRV <input type="checkbox"/></p> <p>Date Administered: _____</p> <p>Manuf/Lot# _____ EXP: _____</p> <p>Site: <u>SQ</u></p>
<p>IPV <input type="checkbox"/></p> <p>Date Administered: _____</p> <p>Manuf/Lot# _____ EXP: _____</p> <p>Site: <u>SQ</u></p>	<p>Varicella <input type="checkbox"/></p> <p>Date Administered: _____</p> <p>Manuf/Lot# _____ EXP: _____</p> <p>Site: <u>SQ</u></p>
<p>Rotavirus <input type="checkbox"/> Teq <input type="checkbox"/> Rix <input type="checkbox"/></p> <p>Date Administered: _____</p> <p>Manuf/Lot# _____ EXP: _____</p> <p>Site: <u>ORAL</u></p>	<p>Hib <input type="checkbox"/> Pedvax Hib <input type="checkbox"/></p> <p>Date Administered: _____</p> <p>Manuf/Lot# _____ EXP: _____</p> <p>Site: <u>IM</u></p>
<p>PCV <input type="checkbox"/></p> <p>Date Administered: _____</p> <p>Manuf/Lot# _____ EXP: _____</p> <p>Site: <u>IM</u></p>	<p>DTaP/Hepatitis B/IPV <input type="checkbox"/> DTaP/Hib/IPV <input type="checkbox"/></p> <p>Date Administered: _____</p> <p>Manuf/Lot# _____ EXP: _____</p> <p>Site: <u>IM</u></p>
<p>Hepatitis B <input type="checkbox"/> Hepatitis A <input type="checkbox"/></p> <p>Date Administered: _____</p> <p>Manuf/Lot# _____ EXP: _____</p> <p>Site: <u>IM</u></p>	<p>Meningococcal (MCV4) <input type="checkbox"/></p> <p>Date Administered: _____</p> <p>Manuf/Lot# _____ EXP: _____</p> <p>Site: <u>IM</u></p>
<p>HPV <input type="checkbox"/></p> <p>Date Administered: _____</p> <p>Manuf/Lot# _____ EXP: _____</p> <p>Site: <u>IM</u></p>	<p>DTaP/IPV <input type="checkbox"/></p> <p>Date Administered: _____</p> <p>Manuf/Lot# _____ EXP: _____</p> <p>Site: <u>IM</u></p>

PLEASE CHECK THE ANSWER TO THE QUESTIONS BELOW AND SIGN YOUR NAME

*** THE INFORMATION IN THE PARENTHESIS IS FOR OFFICE USE ONLY ***

NAME OF PERSON TO RECEIVE VACCINE: _____ Male Female

- | | | YES | NO |
|-----|--|--------------------------|--------------------------|
| 1) | Does this person have a fever or is this person ill at this time with anything other than a cold? (MMR, Hib, Hep. B, Td, Varicella, DTaP, IPV, PCV, MCV4, Tdap, Hep. A, Rotavirus, HPV) | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) | Has this person had a SERIOUS reaction to immunization such as fever greater than 105°, convulsions, total collapse or shock, a high-pitched cry or screaming episode of 3 hours or more, severe itching rash or anaphylactic allergic reaction? (MMR, Hib, Td, Hep. B, DTaP, Varicella, IPV, PCV, MCV4, Tdap, Hep. A, Rotavirus, HPV) | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) | Has this person had a convulsion (seizure) or is this person suspected to have a disease or problem of the brain or nervous system? (DTaP, Tdap, MMRV) | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) | Does this person have a family history (i.e., sibling or parent) of seizures? (MMRV) | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) | Is this person taking a drug or undergoing a treatment that lowers the body's resistance to infection (such as cortisone, prednisone, other steroids, or certain anticancer drugs) or irradiation? (MMR, Varicella, Rotavirus) | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) | Does this person have cancer, leukemia, lymphoma, HIV/AIDS or a disease that lowers the body's resistance to infection? (MMR, Varicella, Rotavirus) | <input type="checkbox"/> | <input type="checkbox"/> |
| 7) | Has this person had an allergic reaction to a vaccine containing diphtheria toxoid so serious that it required medical treatment? (Hib, Td, DTaP, PCV, MCV4, Tdap) | <input type="checkbox"/> | <input type="checkbox"/> |
| 8) | Is this person allergic to an antibiotic called 1) Neomycin 2) Streptomycin or 3) Polymyxin B or allergic to 4) gelatin 5) yeast 6) 2 - Phenoxyethanol 7) aluminum? (MMR - 1,4; Varicella - 1,4; Hep B - 5; IPV - 1,2,3; Hep. A - 1,6,7; HPV - 5,7) | <input type="checkbox"/> | <input type="checkbox"/> |
| 9) | Has this person received gamma globulin, an antiviral drug, blood or blood products within the past year? (MMR, Varicella, Rotavirus) | <input type="checkbox"/> | <input type="checkbox"/> |
| 10) | Is the person receiving immunizations pregnant? (MMR, Td, Varicella, MCV4, HepA, HPV); (Hep B, IPV, Tdap - refer to PMP) | <input type="checkbox"/> | <input type="checkbox"/> |
| 11) | Has this person received immunizations in the last four weeks? (MMR, Varicella, Rotavirus) | <input type="checkbox"/> | <input type="checkbox"/> |
| 12) | Does this person have known allergic reactions (generalized hives, wheezing, swelling of mouth and throat, difficulty breathing, hypotension & shock) to dry natural rubber latex? (MCV4, Comvax, PCV, Tdap - Boostrix prefilled, Rotarix) | <input type="checkbox"/> | <input type="checkbox"/> |
| 13) | Does this person have a history of Guillain-Barre' Syndrome (GBS)? (Tdap, Td) | <input type="checkbox"/> | <input type="checkbox"/> |
| 14) | Has this person ever had a low platelet count (a blood disorder)? (MMR) | <input type="checkbox"/> | <input type="checkbox"/> |
| 15) | Does this person have a preexisting chronic gastrointestinal disease or has this person ever had intussusception (bowel obstruction)? (Rotavirus) | <input type="checkbox"/> | <input type="checkbox"/> |

I give the Lee County Health Department permission to provide an immunization record to the parent/guardian/accompanying adult and/or the person's doctor listed below, and/or other collaborating medical service providers, childcare centers/preschools, Head Start, schools, and/or insurance companies.

Doctor's Name: _____

X

 Signature of Parent, Guardian or Accompanying Adult Relationship Parent's Phone

Please complete upper half of reverse side. →