Pediatrix
"We Care For Kids"

PATIENT NAME: _____ PATIENT ID #:_____

VACCINE FOR CHILDREN SCREENING FORM

This child qualifies for vaccination through the VFC program because he/she is age birth-17 and is:

A) Enrolled in Kid Care_____ B) Enrolled in AHCCCS_____

C) Does not have health insurance_____ D) An American Indian or Alaskan native_____

E) Has health insurance that does not pay for vaccines_____

F) This child has insurance that pays for vaccines and does not qualify for the VFC program_____

Please be advised, if your insurance company does not cover immunizations and you do not let Pediatrix know at the time of your visit, it is your responsibility to pay the full vaccine cost. Pediatrix cannot make the Vaccine for Children Program retroactive and you are only eligible for the Vaccine for Children Program at the time of the visit. If you are unsure if immunizations and well-checks are covered please contact your insurance company.

SIGNATURE: _____ DATE: _____

IMMUNIZATION SCREENING INFORMATION

	Yes	No
1. Is the person being immunized sick with something more serious than a minor illness?	_____	_____
2. Has the person being immunized ever had a reaction after an immunization that required a visit to the doctor or hospital?	_____	_____
3. Is the person being immunized allergic to neomycin or streptomycin?	_____	_____
4. Is the person being immunized allergic to eggs or gelatin?	_____	_____
5. Has the person being immunized received gamma globulin or V-ZIG in the past 5 months?	_____	_____
6. Is the person being immunized pregnant or planning to become pregnant in the next 3 months?	_____	_____
7. Has the person being immunized received any blood products in the past 6 months?	_____	_____
8. Has the person being immunized, or any one in the household, had or have any of the following conditions:		
- HIV-positive or AIDS	_____	_____
- Infections due to immunity problems	_____	_____
- Treatment for cancer	_____	_____
- Leukemia	_____	_____
- Taking a steroid or cortisone medication	_____	_____
- Had an organ transplant	_____	_____

SIGNATURE: _____ DATE: _____

IMMUNIZATION CONSENT FORM

"I have been provided a copy of the appropriate Centers for Disease Control and Prevention Vaccine Information Sheet(s) and have read, or have had explained to me, information about the diseases and vaccines listed below. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccines cited, and ask that the vaccine(s) listed below (including any appropriate combinations vaccines) be given to me or the person named above, for whom I am authorized to make this request."

dT/Td/TdaP_____ DtaP_____ HIB_____ IPV_____

MMR_____ HBV_____ HAV_____ VZV_____ HPV_____

FLU_____ PCV-7_____ PPV-23 _____ Rotavirus_____ Meningococcal_____

OTHER_____ Print Vaccine Name(s)

SIGNATURE: _____ DATE: _____