PATIENT NAME: _____ **PATIENT ID #:** _____

VACCINE FOR CHILDREN SCREENING FORM

This child has insurance or is 19-years of age or older, and does not qualify for the VFC program_____

This child qualifies for VFC program because he/she is age birth-18 and:

A) Is enrolled in Kid Care_____ B) Is enrolled in AHCCCS_____

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

SIGNATURE: _____ **DATE:** _____

IMMUNIZATION SCREENING INFORMATION

	Yes	No
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. Has the child had a health problem with lung, heart, kidney or metabolic disease, (e.g.., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	_____	_____
5. If the child to be vaccinated is 2-4 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/she has had intussusception?	_____	_____
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervoussystem problems?	_____	_____
8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	_____	_____
9. In the past 3 months, has the child taken medications that weaken their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?	_____	_____
10. In the past years, has the child received a transfusion or blood products, or been given immune (gamma) globulin or an antiviral drug?	_____	_____
11. Is the child/teen pregnant or is there a chance she could become pregnant in the next month?	_____	_____
12. Has the child received vaccinations in the past 4 weeks?	_____	_____

SIGNATURE: _____ **DATE:** _____

IMMUNIZATION CONSENT FORM

Td/TdaP_____ DtaP_____ HIB_____ IPV_____

MMR_____ HBV_____ HAV_____ VZV_____ HPV_____

FLU_____ PCV-13_____ PPSV_____ Rotavirus_____ Meningococcal_____

OTHER (Print Vaccine Names): _____

"I have been offered a copy of the appropriate CDC Vaccine Information Sheet(s) and have read, or had explained to me, information about the diseases and vaccines listed above. 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 for the vaccine(s) listed above (including combination vaccines) be given to me or the person named above, for whom I am authorized to make this request."

SIGNATURE: _____ **DATE:** _____

The information above was reviewed by:_____ _____

(Print and Sign Name) (Date)