

Screening Checklist for Contraindications to Vaccines for Children and Teens

PATIENT NAME _____

DATE OF BIRTH ____/____/____
month / day / year

For parents/guardians: The following questions will 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 questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Is the child sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the child have allergies to medicine, food, a vaccine component, or latex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the child had a serious reaction to a vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the child have a long-term health problem with heart, lung (including asthma), kidney, liver, nervous system, or metabolic disease (e.g., diabetes), a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are they taking regular aspirin or salicylate medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. For children age 2 through 4 years: Has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. For babies: Have you ever been told the child had intussusception?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has the child, a sibling, or a parent had a seizure; has the child had a brain or other nervous system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Has the child ever been diagnosed with a heart condition (myocarditis or pericarditis) or have they had Multisystem Inflammatory Syndrome (MIS-C) after an infection with the virus that causes COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Does the child have an immune-system problem such as cancer, leukemia, HIV/AIDS?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. In the past 6 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs to treat rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Does the child's parent or sibling have an immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. In the past year, has the child received immune (gamma) globulin, blood/blood products, or an antiviral drug?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Is the child/teen pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Has the child received vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Has the child ever felt dizzy or faint before, during, or after a shot?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Is the child anxious about getting a shot today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

Did you bring your immunization record card with you? yes no

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.



FOR PROFESSIONALS www.immunize.org / FOR THE PUBLIC www.vaccineinformation.org

www.immunize.org/catg.d/p4060.pdf
Item #P4060 (12/15/2023)



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**Pediatric Vaccines
Patient Eligibility Screening Record**
Beginning 9-6-2023



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. Eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure that the child's eligibility status has not changed since the last visit. Children who have Medicaid must have their eligibility verified in Medi before vaccinations are administered at each visit. 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 publicly funded vaccine, 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 VFC vaccines. If column E or F is marked the child is not eligible for publicly funded vaccine.*

	Eligible for VFC Vaccine				Not eligible for VFC Vaccine	
	A	B	C	D	E	F
Date	Medicaid Enrolled (V02)	No Health Insurance (V03)	American Indian or Alaska Native (V04)	*Underinsured served by FQHC, RHC or deputized LHD (V05)	Has health insurance that covers vaccines (V01)	**Other underinsured (V01)

Footnotes:

* 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/local/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.



MONROE COUNTY HEALTH DEPARTMENT

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CONSENT and ACKNOWLEDGMENT

Receipt of Joint Notice of Privacy Practices

I, _____ do hereby consent to allow the Monroe County Health Department and its designated employees and contractors to assess, evaluate, provide care, bill for services and/or refer me. I understand the nature and consequences of any procedures to be performed will be explained to me.

I understand that the health department is already authorized to use the information gained during treatment to bill me, my insurance company, or any other potential sources of reimbursement, such as government programs in which I am enrolled or qualify for services.

I also hereby acknowledge that I received a copy of the "Joint Notice of Privacy Practices" from the health department dated April 14, 2003.

(X) _____

Sign

(X) _____

Date

Check I any of the following apply:

- Parent or Guardian of Minor Health Care Surrogate
- Power of Attorney for HealthCare Mental Health Treatment Preference Declaration Agent
- Guardian with power to make health care decisions

FOR STAFF USE ONLY:

I attempted to obtain an Acknowledgment of the Receipt of the Notice of Privacy Practices on behalf of the health department. The health department was unable to obtain the acknowledgment because:

Client refuses to sign Other (specify): _____

_____ (Staff Member's Initials) _____ (Date)

(Staff: Place Acknowledgment in patient's medical record)