PATIENT ELIGIBILITY SCREENING RECORD

State Form 48514 (R3 / 3-11)
Indiana State Department of Health, Immunization Division

INSTRUCTIONS:
1. *A record of all children eighteen (18) years of age or younger who receive immunizations must be kept in the health care provider's office.*
2. *The record may be completed by the parent, guardian, or individual of record or by the health care provider.*
3. *Complete all information in section A at the initial screening visit.*
4. *Log the screening date and initial the appropriate eligibility category below for each vaccination.*

A. Patient Information

Child's Name _____ Child's Date of Birth *(month, day, year)* _____

Primary Provider's Name _____

B. Initial Patient Eligibility Screening

Date *(month, day, year)* _____ Initial Screening Record Completed By _____
(Parent/Guardian/Individual of Record/Healthcare Provider)

- ☐ **Medicaid** A child who has any form of Medicaid insurance.
- ☐ **American Indian/Alaskan Native** A child who identifies as an American Indian or Alaskan Native, regardless of insurance.
- ☐ **No Health Insurance** A child who does **not** have health insurance.
- ☐ **Insurance Does Not Cover Vaccines** A child who has commercial (private) health insurance but the coverage does not include vaccines, children whose insurance covers only selected vaccines (these children are categorized as underinsured for non-covered vaccines only), or children whose insurance caps vaccine coverage at a certain amount (once that coverage amount is reached, these children are categorized as underinsured).
- ☐ **Fully Insured** A child who has health insurance which provides coverage for vaccines.

C. VFC eligibility screening must take place with each immunization visit to ensure the child's eligibility status has not changed. This same record can be used for the Initial Patient Eligibility Screening and all subsequent vaccinations. It is necessary to retain this or a similar record for each child receiving vaccine.

The record may be completed by the parent, guardian, or individual of record or by the health care provider.
Log the Screening Date, Status Change and Initial the appropriate eligibility category below for each vaccination.

Eligibility Screening Verification Date *(month, day, year)*	**Eligibility Status Change?**	**Medicaid**	**American Indian/Alaskan Native**	**No Health Insurance**	**Insurance Does Not Cover Vaccines**	**Fully Insured**
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					

School Immunization Clinic Parental Consent Form

School Name _____ Clinic Date _____

In order for your child to obtain the adolescent vaccinations during this school based clinic, you must
1. **Complete** both sides of this form, 2. **Provide** previous vaccination records, and 3. **Sign & Date** this form.

A. INFORMATION ABOUT PERSON RECEIVING VACCINE (PLEASE PRINT)

Student's Name Last _____ First _____ Middle _____

Student's Birth Date _____ Age _____ Gender ☐ *Male* ☐ *Female*

Parent/Guardian Name Last _____ First _____ Relationship _____

Student's Address _____ City _____ Zip Code _____

B. VACCINE ELIGIBILITY SCREENING (PLEASE CHECK APPROPRIATE BOX)

☐ **Medicaid** A child, 0 through 18 years of age, who has Medicaid as primary insurance.

☐ **American Indian/Alaskan Native** A child, 0 through 18 years of age, who identifies as an American Indian or Alaskan Native, regardless of insurance.

☐ **No Health Insurance** A child, 0 through 18 years of age, who does not have health insurance.

☐ **Insurance Does Not Cover Vaccines (Underinsured)** A child, 0 through 18 years of age, who has commercial (private) health insurance but the coverage does not include vaccines, children whose insurance covers only selected vaccines (these children are categorized as underinsured for non-covered vaccines only), or children whose insurance caps vaccine coverage at a certain amount (once that coverage amount is reached, these children are categorized as underinsured).

☐ **Fully Insured** A child, 0 through 18 years of age, who has health insurance which provides coverage for vaccines. If primary insurance denies the claim and Medicaid is a secondary insurance, the healthcare provider will make the adjustment and bill Medicaid.

C. VACCINE HEALTH SCREENING (CIRCLE YES OR NO)

Please answer all questions about the student who will be receiving the vaccine(s). Answers will determine whether the student can be vaccinated at this time.

Yes ☐ No ☐ 1. Does the student have any allergies to medication, foods, or any vaccines?
If yes, please explain _____

Yes ☐ No ☐ 2. Has the student had a serious reaction to a vaccine in the past?

Yes ☐ No ☐ 3. Has the student had a health problem with asthma, lung disease, heart disease, kidney disease, metabolic disease (i.e. diabetes), or a blood disorder?

Yes ☐ No ☐ 4. Has the student had a seizure, brain or other nervous system problem, including Guillain-Barré Syndrome?

Yes ☐ No ☐ 5. Does the student have cancer, leukemia, AIDS, active tuberculosis or any other immune system problem?

Yes ☐ No ☐ 6. Has the student taken cortisone, prednisone, other steroids or anticancer drugs or had radiation treatments in the past three (3) months?

Yes ☐ No ☐ 7. Has the student received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug in the past year?

Yes ☐ No ☐ 8. Is the student pregnant or is there a chance she could become pregnant during the next month? *If yes, student should not receive MMR, HPV, or varicella vaccines.*

Yes ☐ No ☐ 9. Has the student received vaccinations in the past four (4) weeks?
If yes, please list vaccines _____

D. CONSENT TO VACCINATE

I have been given a copy and I have read, or had explained to me, the information in the Vaccine Information Statement(s) for the each vaccine my child will be receiving. I have had a chance to ask questions and fully understand the benefits and risks of each of the indicated vaccines and ask the following vaccines be given to my child on the scheduled school clinic date (check all that apply):

☐ Meningococcal ACWY (MCV4)
☐ Meningococcal Serogroup B (MenB)
☐ Polio
☐ Hepatitis A
☐ Tetanus, diphtheria, acellular pertussis (Tdap)
☐ Measles, mumps, rubella (MMR)
☐ Diphtheria, tetanus, acellular pertussis (DTaP)
☐ Varicella (Chickenpox)
☐ Hepatitis B
☐ HPV

School Immunization Clinic Parental Consent Form

I give permission to the Lake County County Health Department, the Indiana State Department of Health, and/or their designees to vaccinate the student named on this form.

Signature of Parent/Guardian _____ Date _____

E. To Be Completed by Person Administering Vaccine

Vaccine	Manufacturer/Lot Number/ Expiration Date	Signature of Vaccinator	Site	Route	Date of VIS
MCV4			Left or Right Deltoid	IM	
Tdap			Left or Right Deltoid	IM	
Varicella			Left or Right Arm	SC	
MMR			Left or Right Arm	SC	
IPV			Left or Right Arm	SC IM (Please circle)	
Hep B			Left or Right Deltoid	IM	
Hep A			Left or Right Deltoid	IM	
DTaP			Left or Right Deltoid	IM	
HPV9			Left or Right Deltoid	IM	
MenB			Left or Right Deltoid	IM	

The HPV and MenB vaccines are not school requirements. However, it is a requirement of school-based clinics enrolled in the VFC program to offer the HPV and MenB vaccines to both boys and girls.

Entered into CHIRP by _____ Date _____