Iowa HHS
Vaccines for Children Program
Patient Eligibility Screening
Record Private Provider

Initial Screening Date: _____

Child: _____
Last Name / First Name / MI

Date of Birth: _____

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

Primary Health Care Provider's Name: _____

The Vaccines for Children (VFC) program is a federally funded program requiring screening and documentation of eligibility status for all patients from birth through 18 years of age. A record must be kept in the health care provider's office that reflects the status of all children receiving immunizations through the VFC Program. The record may be completed by the parent, guardian or individual of record or by the health care provider and should be used for all subsequent visits. It is necessary to retain this or a similar record for each child receiving vaccine for a minimum of three years.

Indicate the child's eligibility status (check only one box):

(a) Enrolled in Medicaid (copy of MCO member ID card required) ☐

(b) Uninsured-no health insurance coverage ☐

(c) American Indian or Alaskan Native (AI/AN) ☐

(d) Not eligible for the VFC Program because they do not meet the above criteria (insured) ☐

Office Use Only

This record should be used to document VFC eligibility for all subsequent vaccinations. Information below should be completed by clinic staff.

Eligibility Changes					
Date	Medicaid	No health insurance	AI/AN	Not eligible for VFC	Staff Initials

BUENA VISTA COUNTY PUBLIC HEALTH & HOMECARE

Public Health
Prevent. Promote. Protect.

Buena Vista County Public Health
Status Questionaire & Release

Patients Name:_____ DOB:_____

THESE QUESTIONS PERTAIN TO THE PERSON RECEIVING IMMUNIZATIONS

		Yes	No
1	Do you have HAWKI Insurance?	_____	_____
2	Have you had a fever, servere cold, nasea, vomiting, and/or diarrhea within the last 24 hours?	_____	_____
3	Are you currently taking any medications? If so, what? _____How many days on the medicine? _____	_____	_____
4	Have you ever had the Chicken Pox Disease?	_____	_____
5	Have you received Varicella (Chicken Pox) vaccine in the last 30 days?	_____	_____
6	Have you ever had an allergic reaction to any other immunizations? If so, which vaccine?_____	_____	_____
7	Are you or anyone in your family immunocompromised or receiving treatment for cancer, HIV, taking Prednisone or any other drugs affecting your immune system?	_____	_____
8	Do you have any neurological disease or have a history of seizures or convulsions?	_____	_____
9	Do you have any Allergies? (Check which may apply) Eggs:_____ Neomycin:_____ Yeast:_____ Other:_____	_____	_____
10	Age:_____ Estimated Weight:_____(lbs)		
11	Are you currently pregnant, have a possibility of becoming pregnant, or plan to be pregnant in the next 3 months?	_____	_____
12	Have you received the vaccine information sheet(s) for the immunizations you are receiving today?	_____	_____

I hearby release Buena Vista County Public Health and its Agencies, Boards, Board Members, and/or Employees from any and all liability associated with this immunization process.

I authorize the realease of my child's immunization records to the Schools, Pre-Schools, and Day Care Providers per request.

Parents Signature:_____ Date:_____

Reviewer Signature:_____ Date:_____

Comments: _____