

M F

**Last**                      **First**                      **Middle**                      **Sex**                      **Race**                      **Birth Date**                      **Age**

**Address**                      **City**                      **State**                      **Zip**                      **County**                      **Telephone**

**Mother's Name**                      **Mother's Maiden Name**                      **Father's Name**                      **Name of Child's School**

**TVFC ELIGIBILITY**

- Enrolled in Medicaid
- No Health Insurance
- American Indian or Alaskan Native
- Patient who receives benefits from CHIP
- Underinsured (has health insurance that DOES NOT pay for vaccines, has a co-pay or deductible the family cannot meet, or has insurance that provides limited wellness or prevention coverage)
- Is served by any type of public health clinic and does not meet any of the above criteria
- Has private insurance and can pay for services

**Parent/Guardian Signature** \_\_\_\_\_

**SCREENING**

1. Is Child Sick Today?                      Yes    No
2. Does Child have allergies to medications, food, vaccine?    Yes    No
3. Has Child had a serious reaction to a vaccine?                      Yes    No
4. Does/Has Child have health problems like asthma, lung, Heart, kidney disease, cancer, AIDS, or any health problem?    Yes    No
5. Has Child had a seizure or a brain disorder?                      Yes    No
6. Has Child taken cortisone, prednisone, or other steroid in the past 3mths?                      Yes    No
7. Has Child received a transfusion of blood or blood product or been given immune (gamma) globulin in the past year?                      Yes    No
8. Is the Child/Teen pregnant or is there a chance she could become pregnant during the next month?                      Yes    No
9. Has the Child had vaccines/shots in last 4 weeks?                      Yes    No
10. Has the Child had Chickenpox, if so when?                      \_\_\_\_\_ No

Mth/ Yr

**Screeener  
Signature** \_\_\_\_\_

**CONSENT**

I received or was offered a copy of the Vaccine Information Statement (VIS) for each vaccine. I know the risks of the disease each vaccine prevents. I know the benefits and risks of each vaccine. I have had a chance to ask questions about the disease, the vaccines, and how the vaccines are given. I know that the person receiving the vaccine will have the vaccine put into his/her body to prevent the infectious disease. I am an adult who can legally consent for the person named above to get the vaccine. I freely and voluntarily give my signed permission for the vaccines.

**Parent/Guardian Signature**                      **Date**

**Relationship to Child**

Date Given	Vaccine Given	Mfg	Lot #	Site Used	VIS Date	Adm. Initials
	<b>Rotavirus</b> <i>6-32wks</i>	GSMK Merck			E:8-28-08	
	<b>Pediarix</b> <i>6wk-6y</i> <i>Dtap/HepB/IPV</i>	GSMK			See individ. Vacc VIS	
	<b>Pentacel</b> <i>6wk-5y</i> <i>Dtap-IPV/HIB</i>	Sanofi			See individ. Vacc VIS	
	<b>HIB</b> <i>&lt;5y</i>	Sanofi			12-16-98	
	<b>PCV-7</b> <i>&lt;5y</i>	Wyeth			E: 12-9-08	
	<b>HEP B</b> <i>0-18y</i>	GSMK Merck			7-18-07	
	<b>DT</b> <i>6wk-6y</i> <i>Hx seizures</i>	Sanofi			5-17-07	
	<b>KINRIX</b> <i>4-6y</i> <i>DTaP/IPV</i>	GSMK			See individ. Vacc VIS	
	<b>DTaP</b> <i>6wk-6y</i>	GSMK Sanofi			5-17-07	
	<b>IPV</b> <i>6wk-18y</i>	Sanofi			1-1-00	
	<b>MMR</b> <i>1-18y</i>	Merck			3-13-08	
	<b>Varicella</b> <i>1-18y</i>	Merck			3-13-08	
	<b>HEP A</b> <i>1-18y</i>	GSMK Merck			3-21-06	
	<b>Td</b> <i>7-10y</i> <i>11-18y hx seizure</i>	Sanofi			E: 11-18-08	
	<b>Tdap</b> <i>11-18y</i>	GSMK Sanofi			E: 11-18-08	
	<b>HPV</b> <i>9-18y</i>	GSMK MERCK			2-2-07	
	<b>MCV4</b> <i>11-18y</i>	Sanofi			1-28-08	
	<b>Pedi Flu</b> <i>&lt;3yr</i>	Sanofi				
	<b>Flu</b> <i>&gt;3yr</i>	Sanofi				
	<b>Flumist</b> <i>2-18y</i>	Medimmune				

**Administrator Signature** \_\_\_\_\_

\*Notes \_\_\_\_\_