Vaccines for Children (VFC) Program
Patient Eligibility Screening Report

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. The record may be completed by the parent, guardian, individual of record, or by the health care provider. VFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure the child's eligibility status has not changed. While verification of responses is not required, 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.Your Child's Doctor's Name:____

Last Name First Name MI

5. To determine if a child (0 through 18 years of age) is eligible to receive federal vaccine through the VFC and state programs, 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 the VFC program. **If column E, F OR G is marked the child is NOT eligible for federal VFC vaccine.**

	Eligible for VFC Vaccine				Not Eligible for VFC Vaccine		
	A	B	C	D	E	F	G
DATE	Medicaid Enrolled Title XIX (19) (V02)	No Health Insurance (V04)	American Indian or Alaskan Native (V04)	*Underinsured at FQHC, RHC or deputized LHD only (V05)	Has health insurance that covers vaccines (V01)	**Other underinsured (V01)	****Enrolled in CHIP/Medicaid Title XXI or State Funded (V22)

*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 RUAL 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 local health department.

***Children who are enrolled in separate state Children's Health Insurance Program (CHIP) with Medicaid Title XXI (21) or State Funded coverage are considered insured and are NOT eligible for Vaccines through the VFC program.

Revised 09/27/2016

VFC ☐
317 ☐
Private ☐
Chip ☐

Children's Influenza Vaccination

Assessment, Release and Consent Form

Child's Name:_____________________ Gender: M___ F____ Date:_____________

Address:_____________________________________ City:_______________ State:_____

Zip:__________ Birth Date:_________ Age____

Your Home Phone #:_________________Physician:_________________________________

Assessment of Influenza immunizations status

- Has the child received an influenza vaccination this year? Yes No
- Has the child ever had a severe reaction to a flu shot? Yes No
- Is the child allergic to eggs? Yes No
- Has the child ever had Guillain-Barre? Yes No
- Is the child currently running a fever? Yes No

I have read the information or have had the information explained to me. I have had a chance to ask questions and these have been answered to my satisfaction. I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me, or to the person named above for whom I am authorized to make this request. I accept responsibility for seeking medical attention for any problems with this vaccination. I authorize billing of this vaccination to my health insurance. I also acknowledge that I have had an opportunity to receive a copy of the "Notice of Privacy Practices" dated 9/2013 from the Health Department.

Signature:____

For Nurses Use Only

SITE: RD/LD Lot# ___________ Expiration Date: _________

Manufacturer: _____________ Administered By:________________________