Public Health
Prevent. Promote. Protect.
Tuscarawas County Health Department

Tuscarawas County Health Department: Vaccine Eligibility Form

_____VFC ____Adult 317

Patient's Name: _____ **DOB**: _____ **Phone #**: _____

Address: _____ **Gender: M/F**

Please complete the below questionnaire

Has (Is) this person:	**YES / NO/NA**
Is the child/teen/adult sick today?	
Does the child/teen/adult have allergies to medicine, food, a vaccine component, or latex?	
Has the child/teen/adult had a serious reaction to a vaccine in the past?	
Does the child/teen/adult have a long-term health problem with heart, lung, kidney, or metabolic disease(diabetes), asthma, blood disorder, a cochlear implant, or a spinal fluid leak? It he/she on long-term aspirin therapy?	
For children ages 2 through 4 years: has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	
For babies: have you ever been told that the child had intussusception? (Obstruction of the bowel)	
Has the child, a sibling or a parent had a seizure; has the child had a brain or other nervous system problem? If you are an adult and receiving a vaccine today- have you had a seizure or a brain or other nervous system problem?	
Does the child/teen/adult have an immune-system problem such as cancer, leukemia, HIV/AIDS?	
In the past 6 months, has the child/teen/adult 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?	
Does the child's parents or sibling have an immune system problem? If you are an adult receiving a vaccine today, do you have a parent, or sibling with an immune problem?	
In the past year, has the child/teen/adult received immune (gamma) globulin, blood/blood products or an antiviral drug?	
Is the child/teen/adult pregnant?	
Has the child/teen/adult received vaccinations in the past 4 weeks?	
Has the child/teen/adult ever felt dizzy or faint before, during, or after a shot?	
Is the child/teen/adult anxious about getting a shot today?	
Please Note: If receiving MMR, VAR, Zostavax, LAIV- wait for 2 months before having TB test	

I have received the Notice of Privacy Practice and the important information sheets. I understand the risks and benefits of vaccinations. I agree to receive or have my child/self-receive the following immunizations.

Parent/Guardian or Patient Signature: _____ **Date:** _____

Nurse or MA Signature: _____ **Date:** _____

OFFICE USE ONLY: Eligibility Screening Record for VFC or 317

VFC ONLY: The patient named above qualifies for immunization through the VFC program because he/she or his/her parent/guardian states the child is 18 years of age or younger and:

_____is Medicaid eligible or has Medicaid.
_____is uninsured (does not have private insurance/self pay)
_____is an American Indian or Alaskan Native
_____Health insurance does not cover vaccines (only at federal and rural health centers)
_____***The patient does not qualify for immunizations through VFC program because he/she has health insurance that pays for vaccines.***

ADULT 317 ONLY:

____Uninsured
____Underinsured: *Name of Insurance*_____ *Phone number*_____
Verified requested vaccine is not covered: _____