Tuscarawas County
Public Health Department

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

Address: _____ **M** ☐ **F** ☐

PLEASE BRING A COPY OF THE PATIENT'S IMMUNIZATION RECORD

Please complete the below questionnaire

Has (Is) this person:	**YES**	**NO**
Had a vaccine in the past 4 weeks?	☐	☐
Healthy Today?	☐	☐
Currently taking any medications? If yes, please list:	☐	☐
Any Allergies? If yes Please list:	☐	☐
Had a serious reaction or allergy to a previous vaccine or vaccine component, medication, food or late? (eggs, yeast, streptomycin, neomycin, polymixin B, thimerosal, gelatin? For any other allergies see CDC list or product insert)?	☐	☐
Ever had a seizure, brain, or other nervous system problem including Guillian Barre?	☐	☐
Had a blood transfusion or other blood productions in the past year, or have a bleeding disorder?	☐	☐
Had or currently have cancer, leukemia, AIDS, or any other immune system problem?	☐	☐
Taken cortisone, prednisone, or other steroid or anticancer drug or radiation therapy in the past # months?	☐	☐
Had a gastrointestinal problem or condition (ie. Intussusceptions or currently have sever gastroenteritis today?	☐	☐
Have active untreated TB, asthma, or long-term aspiring therapy?	☐	☐
Pregnant or is there a chance you could become pregnant in the next month?	☐	☐
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 Signature: _____ **Date** _____

Nurse Signature: _____ **Date** _____

Print Form **Submit Form**

OFFICE USE ONLY: Eligibility Screening Record for VFC

The patient named above qualifies for immunization through the VFC program because the 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.***

03/2017 AK