Southwest District Health

Children Eligibility Screening Questionnaire and Consent

Print Client Name: _____ DOB:_____ Age: ____

Gender: Male/Female Telephone Number: _____

Parent or Guardian (Print): _____

Address: _____ City _____ State _____ Zip_____

Race (circle one) White Black Native American Asian Pacific Islander Other **Hispanic/Latino**: Yes/No

Answer Following questions only if you or your child is covered by health insurance:

Name of Insurance Company_____ Group #_____

Name of Insured (person who has policy) _____Insured's ID#_____

Insured's Date of Birth_____ Male/Female Insurance Address_____

		Yes	No	Don't Know
1.	Is your child sick today?	☐	☐	☐
2.	Does he/she have an allergy to medications, a vaccine component or latex?	☐	☐	☐
3.	Has he/she ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4.	Does he/she have a health problem with heart, lung, kidney, metabolic disease (e.g., diabetes) asthma, or blood disorder?	☐	☐	☐
5.	Is he/she on long term aspirin therapy?	☐	☐	☐
6.	Does he/she have cancer, leukemia, HIV/AIDS, or any other immune system problem; or, in the past 3 months, have they taken medications that weaken the immune system such as cortisone, prednisone, other steroids or anticancer drugs or had radiation treatments?	☐	☐	☐
7.	Has the child, sibling or parent had a seizure; or has the child had a brain or other nervous system problem?	☐	☐	☐
8.	In the past year, has he/she received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
9.	Is your child/teen pregnant or could she become pregnant within the next three months?	☐	☐	☐
10.	Has he/she ever had Guillain-Barré syndrome?	☐	☐	☐
11.	Does he/she live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation?	☐	☐	☐
12.	Has he/she received any other vaccinations in the past four weeks?	☐	☐	☐

I have reviewed and answered the questions above to the best of my ability. I have been given a copy and reviewed the Vaccine Information Statement(s). I have had a chance to ask questions and they were answered to my satisfaction. I understand the benefits and risks of the recommended vaccines. I ask that the recommended vaccines be given to my child or to the person named for whom I am authorized to make this request and consent. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the provider of any changes in my child's medical status. I also authorize the healthcare staff to perform the necessary health care services that I may need today. My child's immunization record will be entered into the Idaho Immunization Reminder System (IRIS). Participation in IRIS is voluntary and I may opt out at any time by contacting the Idaho Immunization Program.

I have been given the opportunity to review the HIPAA Disclosure. A copy can be provided to me at my request.

SWDH will bill your insurance; you will be responsible for any remaining balance, not to exceed $60.00 per visit.

For your health and safety, please remain in the designated waiting area 15 minutes after your visit.

Parent / Guardian's Signature: _____ Date: _____

==========**Office Use Only**==========

Medicaid/CHIP___ No Health Insurance ___ Underinsured ___

American Indian/Alaska Native ___ Not Eligible, Name of Insurance Carrier: _____

VIS Statement(s) Provided:

Dtap ____	Hib ____	Var ____	Tdap ____	Men B ____
IPV ____	Hep B ____	MMR ____	MCV4 ____	Flu ____
Prevnar ____	Hep A _____	Proquad _____	HPV _____	Other _____

==========**Nurse Use Only**==========

Pediarix ____	Infanrix ____	Hep A ____	Hep B ____	Pentacel ____	HIb ____
IPV ____	Kinrix ____	MCV4 ____	MMR ____	Proquad ____	Prevnar ____
Tdap ____	Var _____	Flu _____	Other _____	Men B _____	HPV _____

Nurse counseled client / parent / guardian and answered questions regarding:

Final Screener:_____ Vaccinator:_____ Date:_____

Notes:_____

_____