

**Ashland County Health Department
Screening Questionnaire for Child Immunization (0-18 years)**

Child's Name: _____

Date of Birth: _____

*If you answer yes to any of the following questions, please provide an explanation.

- | | | |
|--|---------|--------|
| <u>1. Is the child sick today?</u> | Yes ___ | No ___ |
| <u>2. Is the child on any medications? List:</u> | Yes ___ | No ___ |
| <u>3. Does the child have allergies to medications, food, a vaccine component, or latex?</u> | Yes ___ | No ___ |
| <u>4. Has the child ever had a serious reaction to a vaccine in the past?</u> | Yes ___ | No ___ |
| <u>5. Has the child ever had a seizure, brain/neurological disorder, other nervous system disorder, or Guillain-Barre?</u> | Yes ___ | No ___ |
| <u>6. Does the child have a health problem with heart, lung, asthma, kidney, or metabolic disease (e.g., diabetes), anemia, or other blood disorder?</u> | Yes ___ | No ___ |
| <u>7. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?</u> | Yes ___ | No ___ |
| <u>8. In the past 3 months, has the child taken medications that affect the immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?</u> | Yes ___ | No ___ |
| <u>9. During the past year, has the child received a transfusion of blood, blood products, or been given immune (gamma) globulin or an antiviral drug?</u> | Yes ___ | No ___ |
| <u>10. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?</u> | Yes ___ | No ___ |
| <u>11. In the past 4 weeks, has the child received any vaccinations (including Flu Mist)?</u> | Yes ___ | No ___ |
| <u>12. If your child is a baby, have you ever been told he or she has intussusception?</u> | Yes ___ | No ___ |
| <u>13. Has the child (age 6 years and younger) ever had a blood test for lead poisoning?</u> | Yes ___ | No ___ |
| <u>14. Has the child ever had chicken pox (illness)?</u> | Yes ___ | No ___ |
| <u>15. Will the child be traveling out of the United States in the near future?</u> | Yes ___ | No ___ |

****Please bring a vaccine record with you every time ****

Health Insurance Status/VFC Eligibility

The Vaccines for Children (VFC) program is funded by the U.S. Government. To determine eligibility:

- | | | |
|---|---------|--------|
| <u>Is your child enrolled in Medicaid/Healthy Start?</u> | Yes ___ | No ___ |
| <u>Is your child currently without any health insurance?</u> | Yes ___ | No ___ |
| <u>Is your child a registered American Indian or Alaskan Native?</u> | Yes ___ | No ___ |
| <u>Does your child have insurance that does not cover vaccines?</u> | Yes ___ | No ___ |

Consent for Vaccination

I have read or had read to me the information in the appropriate Vaccine Information Statement (VIS). I've been given the chance to ask questions which were answered to my satisfaction. I am informed of the benefits and risks of the vaccine. I request vaccine(s) be administered to me or the person above whom I am authorized to sign as their parent or guardian.

I have had an opportunity to receive a copy of the Ashland County Health Department's Notice of Privacy Practices.

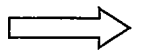
I grant permission for this record to be released to the child's medical provider, school, day care center, WIC, other health department, Ohio Department of Health (ODH), and the state immunization registry, as is required or necessary.

I grant permission for the Ashland County Health Department to submit claims to Medicaid (if the child is enrolled) for reimbursement of their services.

Patient/Parent/Guardian: _____

Date: _____

Continued on other side



***** FOR HEALTH DEPARTMENT NURSE *****

- _____ Immunization history has been reviewed to determine the vaccines which are indicated for the child's age.
- _____ Screening Questionnaire was reviewed, & no contraindications to the above vaccines have been found.
- _____ VIS (s) was given and reviewed with parent, questions have been addressed.
- _____ Parent has been given a reminder slip with the return date of: _____

RN Signature

ASHLAND COUNTY HEALTH DEPARTMENT

1763 State Route 60

Ashland, Ohio 44805

Please write legibly

Clients name: _____ Birthdate: _____

Parent/Guardian name (for minors): _____

Home address: _____

City: _____ State: _____ Zip Code: _____ Township: _____

Home phone: _____ Cell phone: _____

Emergency Contact (NOT person signing today): _____ EC Date of Birth: _____

Relationship (to client): _____ Emergency Contact Phone Number: _____

Client's private physician (if any): _____

Employer or school: _____

Medical insurance company: _____

_____ My insurance does not cover vaccines _____ My employer/school is paying for my vaccines

Please have ready for registration:

1. Vaccine record of the person receiving vaccines today
2. Insurance card (We can bill; Anthem, CareSource, Medicaid, Medicare (red, white & blue card), Medical Mutual, Molina, United Healthcare, United Healthcare Community Plan, R.R. Medicare)
3. Driver's license or ID card of responsible party

Acknowledgement of Financial Responsibility

I understand that my insurance will be billed for services that I/my child receives at the Ashland County Health Department and that I am responsible for any co-pay or deductible imposed by, or charges not covered by my policy. Any outstanding invoices not paid within 90 days will be sent to a collection agency. Each insurance policy is unique and I understand that some services may not be covered.

Please check on of the following:

- _____ I give my permission to bill my insurance provider for services.
- _____ I do NOT give permission to bill my insurance and will self-pay for all services provided to me or my child.
- _____ The above-named patient has no insurance coverage.

I attest that the information provided is accurate, to the best of my knowledge.

Signature: _____ Date: _____

Witness: _____ Date: _____

Office use only:

Amount Paid: _____ cash _____ check# _____ credit/debit _____ Insurance to be billed: _____

VFC eligible (age 18 and under) Yes No Employer/School to be billed: _____

Adult eligible for ODH vaccine _____ NC (unable to pay) _____ Insurance verified by: _____ Clerk initials: _____

_____ Receipt #