Illinois Department of Public Health

Patient Eligibility Screening Record

Vaccine for Children Program (VFC)

VFC eligibility screening must take place with each immunization visit to ensure the child's eligibility status has not changed.

1. Client' s Name _____
   (Last Name) (First Name) (MI)
2. Client's Date of Birth_____ Sex: Male / Female
3. Parent/Guardian (If Child) _____
   (Last Name) (First Name) (MI)
4. Address:_____ _____City/Zip Code _____Phone_____
5. Primary Care Provider/Clinic Name _____
6. This client qualifies for immunizations through the VFC Program because he/she: **(*complete if client is under age 19*)**

   Check only one of the following:

   - Is enrolled in Medicaid
   - Does NOT have health insurance
   - Is an American Indian or Alaska Native
   - Is underinsured (Health insurance that does not pay for vaccinations) or;

   - **This child does not qualify for immunizations through the VFC program because he/she does not meet the eligibility criteria above.**

Signing below acknowledges:

- *I have been provided the Vaccine Information Statement (VIS) regarding the vaccines to be administered at this appointment. I understand the benefits and risks of the vaccines and comfort measures for reactions. I have had a chance to ask questions that were answered to my satisfaction. I understand that this record will be maintained by the Woodford County Health Department (WCHD). I authorize WCHD to release immunization records to the physicians, school, Illinois Department of Public Health and other local Health Departments.*
  Date of VIS(s) Given / Nurse Initials_____
  I authorize WCHD to collect and enter information during the enrollment and registration process to enter into ICARE.
- *I am responsible for the information provided and have completed it to the best of my knowledge.*

Signature (Client/Parent/Guardian) **(Date)**