VFC Patient Eligibility Screening Record
Vaccine Administration Record & Vaccination Consent
School Tdap/Meningitis/Hepatitis B Vaccination/Varicella

School Name: _____ Screening Date: _____

Student's Last Name | First Name | Middle Name

Date of Birth | Birth State | Physician's Name | Gender M or F

Street Address | City | State | Phone

Race: Caucasian African American Asian Multi-racial Am. Indian Hawaiian-Pacific Islander Other

Hispanic Origin: Hispanic Non-Hispanic Unknown

This consent will be used for all subsequent visits as long as the child's eligibility status has not changed.

1. Is the child sick today?	Yes	No	Unsure
2. Does the child have allergies to medications, food, or any vaccine?	Yes	No	Unsure
3. Has the child had a serious reaction to a vaccine in the past?	Yes	No	Unsure
4. Has the child had a seizure or a brain problem?	Yes	No	Unsure
5. Does the child have cancer, leukemia, AIDS or any immune system problems?	Yes	No	Unsure
6. Has the child taken cortisone, prednisone, other steroids, or anti-cancer drugs or had x-ray treatments in the past 3 months?	Yes	No	Unsure
7. Has the child received a transfusion of blood or blood products or been given a medicine called immune (gamma) globulin in the past year?	Yes	No	Unsure
8. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	Yes	No	Unsure
9. Has the child received vaccinations in the past 4 weeks?	Yes	No	Unsure
10. Do you have Private Insurance?	Yes	No	Unsure
11. Do you have Medicaid? If yes, please provide number _____	Yes	No	Unsure
12. Are you uninsured?	Yes	No	Unsure

I have read the Tdap, Meningitis, and Hepatitis B information sheet and have had a chance to ask questions, which were answered to my satisfaction. I believe I understand the benefit and risks of the Vaccines and request that all necessary injections be given to the person named above, for whom I am authorized to make this request. This consent can be revoked at any time during this process.

Authorized signature (Parent/Guardian signature) Date

Signature of Nurse reviewing the form Date

Tdap	Meningitis	Varicella

Signature/Title of Vaccinator Date | Signature/Title of Vaccinator Date | Signature/Title of Vaccinator Date

Tdap	Meningitis	Varicella

Signature/Title of Vaccinator Date | Signature/Title of Vaccinator Date | Signature/Title of Vaccinator Date