Calhoun County Public Health
Screening Checklist for Immunization

PLEASE PRINT CLEARLY Gender: (circle) M F

Individual receiving immunization: _____ Birthdate: ____/____/____
First Name Last Name MI

Address: _____ Phone: _____
Street City Zip Code

Doctor's Name: _____ Parent/Guardian: _____

MCO: Please Check
- ☐ Amerigroup Iowa, Inc.
- ☐ AmeriHealth Caritas Iowa, Inc.
- ☐ United Healthcare Plan of the River Valley, Inc.

Indicate eligibility status (check only one):
- ☐ Is Enrolled in Medicaid: Medicaid #_____
- ☐ DOES NOT have health insurance
- ☐ Is American Indian or Alaskan Native (AI/AN)
- ☐ Is underinsured because health insurance DOES NOT pay for vaccines (Underinsured includes those with health insurance but plan does not include vaccines, covers only select vaccines, or caps the vaccine cost at an established unit)
- ☐ Has Medicare: Medicare # _____
- ☐ Has private insurance. Who with? _____ #:_____ Policy Holder: _____

1. Have you / your child been sick in the last 48 hours? ____Yes ____No
   Temperature _____
2. Do you / your child have any allergies? ____Yes ____No
3. Have you / your child had a serious reaction to a vaccine in the past? ____Yes ____No
4. Have you / your child had a health problem with lung, heart, kidney or metabolic disease - Ex: diabetes, asthma or a blood disorder? ____Yes ____No
5. Have you / your child, sibling, or parent had a history of seizures? ____Yes ____No
6. Females only: Are you / your child / teen pregnant or is there any chance you / she could become pregnant in the next month? ____Yes ____No
7. Have you / your child been vaccinated in the past 4 weeks ____Yes ____No

Comments:_____

_____

By signing below:
- I authorize Calhoun County to bill my insurance. **I know I am responsible for any balance remaining if my insurance denies any part of the bill.**
- I have read and understand the appropriate Vaccine Information Statement (s).
- I have had a chance to ask questions which were answered to my satisfaction.
- I understand the benefits and risk of the vaccines (s) and ask that the vaccine be given to me, or to the person's name for whom I am authorized to make this request.
- I accept responsibility for seeking medical attention for any problems with this vaccination.
- When appropriate, I give Calhoun County Public Health permission to vaccinate my child without parental presence.

X (Please sign) _____
Signature of person to receive vaccine (18 years or older) or Parent/Guardian Date

_____ ____/____/____
Calhoun County Nurse Signature Date

9/6/2017

Client's Name _____ Date of Service_____ **VFC** IRIS Completed on/Staff Initials_____ _____

Staff Signature _____ Initial_____ or

Staff Signature _____ Initial_____ **Private** Billing Completed on/Staff Initials_____ _____

Vaccine	Lot #	Inj Site	Adm By	VIS Version Date	Vaccine	Lot #	Inj Site	Adm By	VIS Version Date
Dtap				5-17-07	HPV, quadrivalent (Gardasil)				3-31-16
Dtap/IPV (Kinrix)				11-16-12	IPV				11-08-11
Dtap, IPV, Hep B (Pediarix)				11-05-15	Meningococcal (Menactra/MCV4)				3-31-16
Dtap, IPV, HIB (Pentacel)				11-05-15	MMR				4-20-12
Influenza 6mo-to 35mo				8-07-15	MMRV (varicella - Proquad)				11-16-12
Influenza 3yrs & older				8-07-15	Pneumococcal conjugate PCV13				11-05-15
Hep A – ped/adol 2 dose				10-25-11	Rotavirus, pentavalent (Rotateq ORAL)				4-15-15
Hep B – ped/adol				2-02-12	Tdap				2-24-15
Hib (PRP-T)				4-02-15	Varicella				3-13-08
Hep A – Adult				10-25-11	Pneumococcal poly PPV23 (adult)				4-24-15
Hep B – Adult				2-02-12	Td (Tenivac)				4-11-17
					Zoster				10-06-09