Jersey County Health Department
1307 State Hwy 109, Jerseyville IL 62052

DEMOGRAPHICS Please Complete ALL Highlighted Areas

Name

Last: _____ **First**: _____ **M.I.**: ___ **Date of Birth:** ____/____/____ **Age:** ___

Address: _____ **County:** _____ **Gender:** M F

City: _____ **State:** _____ **Zip:** _____ **Phone:** _____

Parent/ Guardian: _____ **Physician:** _____

Race: Black/African American White/Caucasian Other_____ **Ethnicity:** Hispanic/Latino Not Hispanic/Latino

Payment Information: ☐ Medicaid - Title XIX (19) *(VFC eligible)* ☐ CHIP - Title XXI (21) or State Funded *(CHIP eligible)*

☐ Uninsured *(VFC eligible)* ☐ American Indian or Alaskan Native *(VFC eligible)*

☐ Private Insurance: _____ Does Insurance Pay for Vaccines? YES NO *(Yes = Insured = Private Pay)*
If Yes, does JCHD have an agreement with my child's insurance to provide vaccinations? YES NO *(Both= Private Pay)*
If No, I have proof that vaccines are not covered by my child's insurance? YES NO *(No = Underinsured = VFC Eligible)*

Put an "x" in the box below to indicate that you have the HIPAA information.

☐ **HIPAA** – I understand a *Notice of Privacy Practices* is available at my request. Under the Healthcare Insurance Portability and Accountability Act, I authorize to disclose my Immunization Record to my child's physician and school. I also authorize the following person(s) to have access to my child's records:
(*It's OK if you don't write anyone's name)* _____

Pediatric Screening Checklist for Contraindications to Vaccines

The following questions will help us to determine which vaccines your child may be given today.
If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated.
It just means additional questions must be asked. If a question is not clear, please ask clinic staff to explain it.

QUESTIONS 1-14	**Yes**	**No**	**Don't Know**
1. Is the child sick today?			
2. Is the child allergic to medications, food (including eggs), a vaccine component, or latex? If yes, list here:			
3. Has the child had a serious reaction to a vaccine in the past?			
4. Does the child have a long-term health problem with lung, heart, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Is he/she on long-term aspirin therapy?			
5. If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?			
6. If your child is a baby, have you ever been told he or she has had intussusception?			
7. Has the child, a sibling or a parent had a seizure? Has the child had brain or other nervous system problems?			
8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?			
9. Does the child have a parent, brother, or sister with an immune system problem?			
10. 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?			
11. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?			
12. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?			
13. Has the child received vaccinations in the past 4 weeks?			
14. Child's age *(circle):* 0-5 months 6 months - 11 years 12years - 18 years			

"I have completed this form to the best of my knowledge. I have been given, read and understand the possible side effects described in the Vaccine Information Statement (VIS) that could be caused by the vaccine(s). I consent for my child to receive vaccinations as indicated. I agree to pay JCHD for any services not covered or paid by my insurance, and I understand that JCHD may bill me for this amount."

Signature: _____ Date: _____
(parent or legal guardian must sign)

Nurse Reviewing Form: _____ Date: _____