Fairfield Department of Health
Immunization Clinic

CHILDREN / TEEN PATIENT REGISTRATION
(18 years or younger)

Patient Information			
First Name	Last Name	MI	Date of Birth
Address	City	State	Zip
Please check Primary phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐
Other Name(s) Used	E-mail Address		
Gender ☐ M ☐ F	SSN	Preferred Language	Driver's License

Marital Status	Preferred Contact	Ethnicity	Race
☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Life Partner	☐ Mail ☐ Home Phone ☐ Day Phone ☐ Cell Phone ☐ Patient Portal (MyChart)	☐ Cambodian ☐ Filipino ☐ Hispanic/Latino ☐ Non-Hispanic	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other

Primary Care Provider	Referring Provider

Responsible Party (Guarantor) ☐ Same as patient			
First Name	Last Name	MI	Date of Birth
Address	City	State	Zip
Please check Primary Phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐
SSN	Relationship to Patient	Preferred Language	Driver's License

Emergency Contact (for minor child, this section may be used for other parent)			
First Name	Last Name	MI	Date of Birth
Address	City	State	Zip
Please check Primary Phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐

Immunization Record Release Authorization:

I authorize the Fairfield Department of Health to release Immunization Records via mail, fax, or email to *(check all that apply)*:
☐ Physicians ☐ Schools/Preschools ☐ Daycare Facilities ☐ Other _____

_____ _____
Signature of Patient or Responsible Party Date

Consent for Additional Party to bring child in absence of parent. (*Optional*)

I (Parent/Guardian Name) _____ am authorizing (Authorizing Party) _____
to bring my child (Child's Name) _____ to any upcoming appointments he/she may have.

Parent/Guardian Signature _____ Date _____

****Please be advised that this statement will not change unless you submit in writing requesting the person you authorized to be removed. Only valid for one year from date signed.**

Financial Consent/Insurance Information:

Primary Ins. Name: _____ Secondary Ins. Name: _____
(e.g. Medicaid, Care Source, Molina, TriCare, UHC-state insurance card, Medigold, Medicare, Paramount, Buckeye, Private Insurance).

Please initial by each statement:.

_____I authorize the Fairfield Department of Health to release pertinent information to my insurance company when requested, or to facilitate payment of a claim.

_____I authorize the Fairfield Department of Health to apply for benefits on my behalf for covered services rendered by the patient and for payment to be made payable to the Fairfield Department of Health.

_____I agree to bring the most current copy of my insurance card with me to each visit and will pay all applicable co-pays or deductibles on the same day I receive medical services.

_____I agree with the consent and the provisions of medical treatment and the financial policy.

_____I understand that the services provided may or may not meet the criteria for coverage under Medficare, Medicaid, and/or other insurance carriers.

_____My initials indicate that I agree to pay all charges/unpaid deductibles regarding this service(s) if Medicare, Medicaid, and/or other private insurance carriers fail to cover the charges.

_____ I hereby declare that I/we do not have any other valid and collectible insurance or indemnity coverage, including, but not limited to, private/supplemental medical insurance, Medicare, or other Medicaid insurances(Ex: Molina, CareSource, Paramount Advantage, etc.) that were in effect during the office visit. (if applicable)

****Please provide your Insurance Card to be copied and placed in your file****

Directions:

Please answer the 4 questions to the **RIGHT.**

VFC Eligibility Determination

1.	Receive Medicaid (ex: Caresource, Molina, etc)	□ Yes	□No
2.	Uninsured	□ Yes	□No
3.	American Indian / Alaska Native	□ Yes	□No
4.	Underinsured – defined below*	□ Yes	□No

***The "Underinsured" category is very narrowly defined for children to be eligible for VFC vaccine in Local Health Departments and Federally Qualified Health Centers. Patients with high deductible or high co-payment costs are never considered "Underinsured."**

For Office Use Only

VFC Eligibility Yes □ No □
Nurse / Clerk Initials _____

Acknowledgment of Receipt of Notice of Privacy Practices:

I acknowledge that I have reviewed a copy of the Notice of Privacy Practices provided to me by the Fairfield Department of Health. I understand that this Notice explains what the Fairfield Department of Health does to protect the use or disclosure of my health care information. I understand that I may request a copy of this Notice to be given to me and will refer to it if I have questions. I also understand that I should call the Health Department at (740) 652-2800 if I have questions or concerns about my privacy rights.
_____ (Initial)

****All Signatures are valid for 1 (one) year.****

Screening Checklist for Contraindications to Vaccines for Children and Teens

PATIENT NAME _____

DATE OF BIRTH ____ / ____ / ____
month day year

For parents/guardians: The following questions will help us 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 your healthcare provider to explain it.

	yes	no	don't know
1. Is the child sick today?	☐	☐	☐
2. Does the child have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? 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. 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?	☐	☐	☐
10. 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?	☐	☐	☐
11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐	☐
12. Has the child received vaccinations in the past 4 weeks?	☐	☐	☐

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

Did you bring your immunization record card with you? **yes** ☐ **no** ☐

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.

immunization action coalition
IAC
immunize.org

Technical content reviewed by the Centers for Disease Control and Prevention

Saint Paul, Minnesota ▪ 651-647-9009 ▪ www.immunize.org ▪ www.vaccineinformation.org

www.immunize.org/catg.d/p4060.pdf ▪ Item #P4060 (2/16)

Information for Healthcare Professionals about the Screening Checklist for Contraindications (Children and Teens)

Are you interested in knowing why we included a certain question on the screening checklist? If so, read the information below. If you want to find out even more, consult the references listed at the end.

1. Is the child sick today? *[all vaccines]*

There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events (1, 2). However, as a precaution with moderate or severe acute illness, all vaccines should be delayed until the illness has improved. Mild illnesses (such as otitis media, upper respiratory infections, and diarrhea) are NOT contraindications to vaccination. Do not withhold vaccination if a person is taking antibiotics.

2. Does the child have allergies to medications, food, a vaccine component, or latex? *[all vaccines]*

An anaphylactic reaction to latex is a contraindication to vaccines that contain latex as a component or as part of the packaging (e.g., vial stoppers, prefilled syringe plungers, prefilled syringe caps). If a person has anaphylaxis after eating gelatin, do not administer vaccines containing gelatin. A local reaction to a prior vaccine dose or vaccine component, including latex, is not a contraindication to a subsequent dose or vaccine containing that component. For information on vaccines supplied in vials or syringes containing latex, see reference 3; for an extensive list of vaccine components, see reference 4. An egg-free recombinant influenza vaccine (RIV3) may be used in people age 18 years and older with egg allergy of any severity who have no other contraindications. Children and teens younger than age 18 years who have experienced a serious systemic or anaphylactic reaction (e.g., hives, swelling of the lips or tongue, acute respiratory distress, or collapse) after eating eggs can usually be vaccinated with inactivated influenza vaccine (IIV); consult ACIP recommendations (see reference 4).

3. Has the child had a serious reaction to a vaccine in the past? *[all vaccines]*

History of anaphylactic reaction (see question 2) to a previous dose of vaccine or vaccine component is a contraindication for subsequent doses (1). History of encephalopathy within 7 days following DTP/DTaP is a contraindication for further doses of pertussis-containing vaccine. Precautions to DTaP (not Tdap) include the following: (a) seizure within 3 days of a dose, (b) pale or limp episode or collapse within 48 hours of a dose, (c) continuous crying for 3 or more hours within 48 hours of a dose, and (d) fever of 105°F (40°C) within 48 hours of a previous dose. There are other adverse events that might have occurred following vaccination that constitute contraindications or precautions to future doses. Under normal circumstances, vaccines are deferred when a precaution is present. However, situations may arise when the benefit outweighs the risk (e.g., during a community pertussis outbreak).

4. Has the child had a health problem with lung, heart, kidney, or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy? *[LAIV]*

The safety of LAIV in children and teens with lung, heart, kidney, or metabolic disease (e.g., diabetes), or a blood disorder has not been established. These conditions, including asthma in children ages 5 years and older, should be considered precautions for the use of LAIV. Children on long-term aspirin therapy should not be given LAIV; instead, they should be given IIV.

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? *[LAIV]*

Children ages 2 through 4 years who have had a wheezing episode within the past 12 months should not be given LAIV. Instead, these children should be given IIV.

6. If your child is a baby, have you ever been told that he or she has had intussusception? *[Rotavirus]*

Infants who have a history of intussusception (i.e., the telescoping of one portion of the intestine into another) should not be given rotavirus vaccine.

7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problem? *[DTaP, Td, Tdap, IIV, LAIV, MMRV]*

DTaP and Tdap are contraindicated in children who have a history of encephalopathy within 7 days following DTP/DTaP. An unstable progressive neurologic problem is a precaution to the use of DTaP and Tdap. For children with stable neurologic disorders (including seizures) unrelated to vaccination, or for children with a family history of seizures, vaccinate as usual (exception: children with a personal or family [i.e., parent or sibling] history of seizures generally should not be vaccinated with MMRV; they should receive separate MMR and VAR vaccines). A history of Guillain-Barré syndrome (GBS) is a consideration with the following: 1) Td/Tdap: if GBS has occurred within 6 weeks of a tetanus-containing vaccine and decision is made to continue vaccination, give age-appropriate Tdap instead of Td if no history of prior Tdap, to improve pertussis protection; 2) Influenza vaccine (IIV or LAIV): if GBS has occurred within 6 weeks of a prior influenza vaccination, vaccinate with IIV if at high risk for severe influenza complications.

8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem? *[LAIV, MMR, MMRV, RV, VAR]*

Live virus vaccines (e.g., MMR, MMRV, varicella, rotavirus, and the intranasal live, attenuated influenza vaccine [LAIV]) are usually contraindicated in immunocompromised children. However, there are exceptions. For example, MMR is recommended for asymptomatic HIV-infected children who do not have evidence of severe immunosuppression. Likewise, varicella vaccine should be considered for HIV-infected children with age-specific CD4+ T-lymphocyte percentage at 15% or greater and may be considered for children age 8 years and older with CD4+ T-lymphocyte counts of greater than or equal to 200 cells/μL. Immunosuppressed children should not receive LAIV. Infants who have been diagnosed with severe combined immunodeficiency (SCID) should not be given a live virus vaccine, including rotavirus (RV) vaccine. Other forms of immunosuppression are a precaution, not a contraindication, to rotavirus vaccine. For details, consult the ACIP recommendations (1, 6, 7, 8).

9. 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? *[LAIV, MMR, MMRV, VAR]*

Live virus vaccines (e.g., LAIV, MMR, VAR, ZOS) should be postponed until after chemotherapy or long-term high-dose steroid therapy has ended. For details and length of time to postpone, consult the ACIP statement (1). Some immune mediator and immune modulator drugs (especially the antitumor-necrosis factor agents adalimumab, infliximab, and etanercept) may be immunosuppressive. The use of live vaccines should be avoided in persons taking these drugs (MMWR 2011;60 [RR2]:23). To find specific vaccination schedules for stem cell transplant (bone marrow transplant) patients, see reference 9. LAIV can be given only to healthy non-pregnant people ages 2 through 49 years.

10. 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? *[LAIV, MMR, MMRV, VAR]*

Certain live virus vaccines (e.g., LAIV, MMR, MMRV, varicella) may need to be deferred, depending on several variables. Consult the most current ACIP recommendations or the current Red Book for the most current information on intervals between antiviral drugs, immune globulin or blood product administration and live virus vaccines (1, 2).

11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month? *[LAIV, MMR, MMRV, VAR]*

Live virus vaccines (e.g., MMR, MMRV, varicella, LAIV) are contraindicated one month before and during pregnancy because of the theoretical risk of virus transmission to the fetus (1, 2). Sexually active young women who receive a live virus vaccine should be instructed to practice careful contraception for one month following receipt of the vaccine (7, 10). On theoretical grounds, inactivated poliovirus vaccine should not be given during pregnancy; however, it may be given if risk of exposure is imminent (e.g., travel to endemic areas) and immediate protection is needed. Use of Td or Tdap is not contraindicated in pregnancy. At the provider's discretion, either vaccine may be administered during the 2nd or 3rd trimester (5, 11)

12. Has the child received vaccinations in the past 4 weeks? *[LAIV, MMR, MMRV, VAR, yellow fever]*

Children who were given either LAIV or an injectable live virus vaccine (e.g., MMR, MMRV, varicella, yellow fever) should wait 28 days before receiving another vaccination of this type. Inactivated vaccines may be given at the same time or at any spacing interval.

REFERENCES

1. CDC. General recommendations on immunization, at www.cdc.gov/mmwr/pdf/rr/rr6002.pdf.
2. AAP. Red Book: Report of the Committee on Infectious Diseases at www.aapredbook.org.
3. Latex in Vaccine Packaging: www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/latex-table.pdf
4. Table of Vaccine Components: www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf.
5. CDC. Prevention and control of influenza with vaccines: Recommendations of the Advisory Committee on Immunization Practices (ACIP), United States, 2015–16 Influenza Season at www.cdc.gov/mmwr/pdf/wk/mm6430.pdf, pages 818–825.
6. CDC. Measles, mumps, and rubella – vaccine use and strategies for elimination of measles, rubella, and congenital rubella syndrome and control of mumps. MMWR 1998; 47 (RR-8).
7. CDC. Prevention of varicella: Recommendations of the Advisory Committee on Immunization Practices. MMWR 2007; 56 (RR-4).
8. Rubin LG, Levin MJ, Ljungman P. 2013 IDSA Clinical practice guideline for vaccination of the immunocompromised host. Clinical Infectious Diseases 2014;58(3):e44–100.
9. Tomblyn M, Einsele H, et al. Guidelines for preventing infectious complications among hematopoietic stem cell transplant recipients: a global perspective. Biol Blood Marrow Transplant 15:1143–1238; 2009 at www.cdc.gov/vaccines/pubs/hemato-cell-transplts.htm.
10. CDC. Notice to readers: Revised ACIP recommendation for avoiding pregnancy after receiving a rubella-containing vaccine. *MMWR* 2001; 50 (49).
11. CDC. Prevention of pertussis, tetanus, and diphtheria among pregnant and postpartum women and their infants: Recommendations of the ACIP. *MMWR* 2008; 57 (RR-4).

Public Health
Prevent. Promote. Protect.
Fairfield Department of Health
Nursing Divison

MAC
MEDICAID AND REFERRAL FORM

Child's Name: _____ **Parent/Guardian/Client Signature:** _____

1.	Are you on Medicaid? (Includes Molina, CareSource, Buckeye….etc)	YES	NO
2.	If no, would you like information on Medicaid?	YES	NO
3.	Do you need help with finding a physician who will accept your child's Medicaid, Molina or CareSource Insurance?	YES	NO
4.	Do you think your child is talking, walking, and doing things like other children his/her age?	YES	NO
5.	Are you interested in Early Head Start, Head Start, and Help Me Grow?	YES	NO
6.	Is your child on WIC (Women, Infants and Children)?	YES	NO
7.	If no, would you like more information on WIC?	YES	NO
8.	Is your child on BCMH (Bureau for Children with Medical Handicaps)?	YES	NO

Nurse Verification (Office Use Only)

Date _____	**Nurse** _____	*Notes*:
Date _____	**Nurse** _____	*Notes*:
Date _____	**Nurse** _____	*Notes:*
Date _____	**Nurse** _____	*Notes:*

1550 Sheridan Dr, Suite 100 • Lancaster, Ohio 43130 • (T) 740.652.2800 • (F) 740.689.6080 • www.myfdh.org • *an equal opportunity employer*

Prevent • Protect • Promote

Date	Nurse	*Notes*:
Date	Nurse	*Notes*:
Date	Nurse	*Notes:*
Date	Nurse	*Notes:*
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Date	Nurse	*Notes*:
Date	Nurse	*Notes:*
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Date	Nurse	*Notes:*