Child's Vaccine Administration Record

Information about Person TO RECEIVE Vaccine (Please print)

NAME - LAST_____ FIRST_____ MI_____

DATE OF BIRTH: AGE: PHONE #:

ADDRESS:

STREET:

CITY: STATE ZIP

"I have read or have had explained to me the information in the Vaccine Information Statement (VIS) about the vaccine(s) that will be administered. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) checked below be given to me or to the person named above for whom I am authorized to make this request."

Signature of person to receive vaccine or authorized to make request: **Date statement(s) provided:**

do not write below - FOR OFFICE USE ONLY!

IPV ☐	DTaP ☐	Td ☐	Tdap ☐
(Inactivated Polio Vaccine)	(Diphtheria, tetanus, and pertussis)	(Tetanus, Diphtheria)	(Tetanus, Diphtheria, Pertussis)
VIS date: 11/08/2011	VIS date: 05/17/2007	VIS date: 01/24/2012	VIS date: 01/24/2012
Vaccine Administration date:	Vaccine Administration date:	Vaccine Administration date:	Vaccine Administration date:
Manufacturer:	Manufacturer:	Manufacturer:	Manufacturer:
Lot #:	Lot #:	Lot #:	Lot #:
ite of Injection: Dose#	ite of Injection: Dose#	ite of Injection: Dose#	Site of Injection: Dose#
HPV : Gardasil or Cervarix ☐	PCV13 ☐	MCV4 ☐	Influenza Injectable ☐
(Human Papillomavirus Vaccine)	(Pneumoccoccal conjugate vaccine)	(Meningococcal conjugate vaccine)	Intranasal ☐
VIS date: 02/22/2012	VIS date: 04/16/2010	VIS date: 10/14/2011	VIS date:
Vaccine Administration date:	Vaccine Administration date:	Vaccine Administration date:	Vaccine Administration date:
Manufacturer:	Manufacturer:	Manufacturer:	Manufacturer:
Lot #:	Lot #:	Lot #:	Lot #:
ite of Injection: Dose#	ite of Injection: Dose#	ite of Injection: Dose#	Site of Injection: Dose#
Varicella ☐	MMR ☐	Hep A ☐	Hep B ☐
(Chickenpox vaccine)	(Measles, Mu8mps & Rubella vaccine)	(Hepatitis A Vaccine)	(Hepatitis B Vaccine)
VIS date: 03/13/2008	VIS date: 04/20/2012	VIS date: 10/25/2011	VIS date: 02/02/2012
Vaccine Administration date:	Vaccine Administration date:	Vaccine Administration date:	Vaccine Administration date:
Manufacturer:	Manufacturer:	Manufacturer:	Manufacturer:
Lot #:	Lot #:	Lot #:	Lot #:
ite of Injection: Dose#	ite of Injection: Dose#	ite of Injection: Dose#	Site of Injection: Dose#
Hib ☐	Pentacel ☐	Kinrix ☐	Rotorix - Rotateq ☐
(Haemophilus Influenzae Type b Vaccine)	(DTaP/IPV/Hib conbined Vaccine)	(DTaP/Polio Vaccine)	(Votavirus Vaccine)
VIS date: 12/16/1998	VIS date: 09/18/2008	VIS date: 11/08/2011	VIS date: 12/06/2010
Vaccine Administration date:	Vaccine Administration date:	Vaccine Administration date:	Vaccine Administration date:
Manufacturer:	Manufacturer:	Manufacturer:	Manufacturer:
Lot #:	Lot #:	Lot #:	Lot #:
ite of Injection: Dose#	ite of Injection: Dose#	ite of Injection: Dose#	Site of Injection: Dose#

Calhoun County Health Department
PO Box 158, 210 French Street
Hardin, Illinois 62047
(618) 576-2428
FAX: (618) 576-9391

Vaccine Administration Signature:

Title:

Date:

Revised: 09/06/2012

CORNERSTONE INFORMED CONSENT FORM

Name of Participant: _____ _____ _____
(Last) (First) (M)

Date of Birth: _____ _____ Male _____ Female _____
(Month) (Day) (Year)

Participant's ID Number _____

It is important that you read the following. If there is anything that you do not understand, or if you have any questions, be sure to ASK.

Welcome to Cornerstone, a system that collects data on a wide range of health care services to individuals. These services include WIC (Women, Infants and Children); Immunizations; Case Management; Prenatal and Postpartum Care; Pediatric Primary Care; Early Intervention; Breast and Cervical Cancer; Diabetes Control; and Healthy Families Illinois.

We are asking for permission to collect information about the participant and store it in a centralized computer system maintained by the Illinois Departments of Human Services and Public Health. Based on the information collected during the enrollment or registration process, we will determine whether you need further service. Only those authorized health care professionals with a direct need to know about you will have access to this information. Information may be released for service authorization, audit, and evaluation purposes. Necessary information, without any client's name, will be sent to federal agencies that fund these programs.

By signing this consent form, you agree to allow certain information to be collected by this agency/clinic. The person(s) receiving this information has a legal and ethical duty to keep the information confidential and private and not release it to anyone else without your written permission unless the law allows it.

A. I authorize Calhoun Co. Hlth. to collect information during the enrollment/registration process.

B. This authorization covers all the medical, social and financial information about the participant, including: participant background and demographic information; health visit information; medical and developmental history; prenatal, birth, and postpartum data; infant/child visit data; immunization records; participant risks; problems or factors that prevent the participant from receiving proper medical care; appointments made and services received; goals and care plan; WIC food packages; program information; information required by the federal Maternal and Child Health Block Grant Program, and Early Intervention. Any information you do not want released should be written in Part D.

C. This authorization also covers information about mental health, AIDS, HIV, sexually transmissible diseases, alcoholism, and drug use, which may be reported by me. I understand that I am not required to report or discuss those matters with anybody.

D. The following information I do NOT want to be shared: _____

E. I am making this consent within the limits of my legal authority. I understand that I may revoke this consent orally or in writing at any time, but that revoking this consent will not cancel what was done before I revoked it. I also understand and agree not to hold the Illinois Departments of Human Services and Public Health liable for the release of any information about me in accordance with the terms of this consent form.

F. A photostatic copy/facsimile of this consent will be as valid as the original

For child participant: OR For adult participant:

_____ _____
Signature of parent/legal guardian/caretaker /Date

Signature of adult participant / Date

Signature of Witness: _____ Date: _____

(06/07)

Screening Questionnaire for Child and Teen Immunization

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If a question is not clear, please ask the doctor or nurse to explain it.

1. Is child sick today, or has the child had a fever over 100 degrees in the past 24 hours?	Yes	No
2. Has child received an immunization in the past 30 days or a TB skin test in the past 3 days?	Yes	No
3. Does child have allergies to any medications, food, or any vaccines?	Yes	No
4. Has the child had a serious reaction to a vaccine in the past?	Yes	No
5. Has the child had a seizure, convulsion, or a brain problem in the past?	Yes	No
6. Does the child, or anyone who lives with or takes care of the child, have cancer, leukemia, AIDS, or any other immune disease?	Yes	No
7. Has child, or any person who lives with or takes care of the child, taken cortisone, prednisone, other steroids, anti-cancer drugs, or had x-ray treatments or radiation in the past 3 months?	Yes	No
8. Has the child received a transfusion of blood or plasma, or been given a medicine called immune (gamma) globulin in the past year?	Yes	No
9. (Females only) Is child/teen pregnant or is there a chance she could become pregnant in the next 3 months?	Yes	No
10. I have read and understand the possible side effects described in the "Vaccine Information Statement", that could be caused by the vaccine.	Yes	No
11. Do you want the child's physician notified of the vaccines given today? (Dr. Name _____)	Yes	No

Parent/ guardian signature: _____ **Date:** _____

Did you bring your child's immunization record with you? (circle one) Yes No

It is important for you to have a personal record of your child's shots. If you don't have a record card, ask the child's doctor or nurse to give you one. Bring this record with you every time you bring your child to the clinic. Make sure your clinic records all you child's vaccinations on it. Your child will need this card to enter daycare, kindergarten, junior high, etc.

Nurse Reviewing Form: _____ **Date** _____

YOUR SHOTS MAY BE FREE!

1. Are you currently on KidCare/Public Aid? ___ Yes ___ No (if yes, please give copy to front desk)

Illinois Department of Public Health

Patient Eligibility Screening Record

Vaccines 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. Initial Screening Date __/__/____ (MM DD YYYY)
2. Child's Name _____ (Last Name) _____ (First Name) _____ (MI)
3. Child's Date of Birth __/__/____ (MM DD YYYY)
4. Parent/Guardian/Individual of record _____ (Last name) _____ (First Name) _____ (MI)
5. Is your practice/clinic a federally qualified health center (FQHC) or rural health clinic (RHC)? Yes___ No___
   If you answered "Yes," you must have a photocopy or electronic copy of your FQHC or RHC license/certification on file with the Illinois Vaccines for Children program.
6. Primary Provider's Name _____ (Last name) _____ (First name) _____ (MI)
7. Does this patient qualify for immunization through the VFC program because he/she : Check only one box
   - Yes, is enrolled in Medicaid ☐
   - Yes, does NOT have health insurance ☐
   - Yes, is an American Indian or Alaska Native ☐
   - Yes, is underinsured (had health insurance that does not pay for vaccinations.* ☐
   - No, this child does not qualify for immunizations through the VFC program because he/she does not meet the eligibility criteria. ☐

* To be supported with VFC purchased vaccine, underinsured children must be vaccinated through a FQHC or RHC. See question 5 above.

Eligibility Changes

Date Eligibility Changed	Medicaid	Uninsured	American Indian / Alaska Native	Underinsured*	Does not meet eligibility criteria

* To be supported with VFC purchased vaccine, underinsured children must be vaccinated through a FQHC or RHC. See question 5 above.

A record of all children 18 years of age or younger who receive immunizations must be kept in the health care provider's office. The record may be completed by the parent, guardian, or individual of record or by the health care provider. VFC eligibility screening must take place with each immunization visit to ensure the child's eligibility status has not changed. This same record will satisfy the requirements for all subsequent vaccinations as long as the child's eligibility status has not changed. It is necessary to retain this or a similar record for each child receiving vaccine.

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