

Name: \_\_\_\_\_ Age: \_\_\_\_\_

**2020-2021 Influenza Vaccine– Screening (Child)**

Please choose which insurance to bill: Insurance 1      Insurance 2      Insurance 3

Other: \_\_\_\_\_

**Information to determine if your child should receive 1 or 2 doses of flu vaccine.**

**If your child is age 9 or older, go to Section 2 below.**

**If your child is age 8 or younger, answer the following questions in this box.**

1. How many total doses of flu vaccine has your child ever received before July 1, 2020?

- No doses     Only 1 dose     2 or more doses

2. Has your child received flu vaccine this flu season (since July 1, 2020)?  **No**     **Yes**

If yes, please tell us the number of doses and dates of vaccination.     1 dose     2 doses

**Dose 1:** Date received: month \_\_\_\_ day \_\_\_\_ 2020    **Dose 2:** Date received: month \_\_\_\_ day \_\_\_\_ 2020

**Section 2: Please check YES or NO for each question**

	NO	YES
1. Does your child have any allergies to medication, foods, or any vaccines?		
2. Has your child ever had a serious reaction to influenza vaccine in the past?		
3. Does your child have a long-term health problem with heart disease, lung disease (including asthma), kidney disease, neurologic disease, liver disease, metabolic disease (e.g., diabetes), or have a cochlear implant or spinal fluid leak, or no spleen?		
4. If your child age 2 through 4 years, in the past 12 months, has a healthcare provider told you they have wheezing or asthma?		
5. Does your child have cancer, leukemia, HIV/AIDS, or any other immune system problem; or, in the past 3 months, have they taken medications that affect the immune system (e.g., prednisone or other steroids, drugs for the treatment of rheumatoid arthritis, Crohn’s disease, psoriasis, or anticancer drugs) or have they had radiation treatments?		
6. Is your child taking influenza antiviral medications?		
7. Is your child pregnant or planning on becoming pregnant within the next month?		
8. Has your child ever had Guillain-Barré syndrome?		
9. Has your child received any other vaccinations in the past 4 weeks?		

**Please explain any ‘Yes’ responses.** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Vaccine Eligibility Screening (Please check appropriate box)**

- Medicaid:** A child, 0 thru 18 years of age, who has Medicaid coverage.
- American Indian/Alaskan Native:** A child, 0 thru 18 years of age, who identifies as an American Indian or Alaskan Native, regardless of insurance coverage.
- No Health Insurance:** A child, 0 thru 18 years of age, who does not have health insurance.
- Limited Health Insurance:** A child, 0 thru 18 years of age, who has health insurance, but the health insurance does not pay for vaccinations.
- Insured:** A child, 0 thru 18 years of age, who has health insurance which provides coverage for vaccines.

**\*\*DO NOT WRITE BELOW THIS LINE\*\***

To be completed by person administering vaccine

Vaccination Date: 09/14/2020		Payer Source		Codes					
EIPHD Office:  1250 Hollipark Drive Idaho Falls, ID 83401 (208)533-3235		Insurance  Medicaid  VFC		90471  Nasal					
Vaccine		Lot Number		Provider Name		Site		Route	
90686	Flulaval 6 mo & up						Left or Right Deltoid: Leg		IM
90674	Flucelvax						Left or Right Deltoid: Leg		IM
90672	Flumist						Nasal		Intranasal
	OTHER						Left or Right Deltoid: Leg: Arm		IM/SQ
	OTHER						Left or Right Deltoid: Leg: Arm		IM/SQ
	OTHER						Left or Right Deltoid: Leg: Arm		IM/SQ

Screening Reviewed and Education Provided by: \_\_\_\_\_

Checked in  Scanned  SuperBilled  Checked out