Texas Vaccines For Children (TVFC) Program
Patient Eligibility Screening Record

A screening record of all children 18 years of age or younger who receive immunizations through the TVFC Program 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 healthcare provider. TVFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure eligibility status for the program. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines under the TVFC Program.

1. Child's Name:____
 Last Name First Name MI

2. Child's Date of Birth:_______________________
 mm/dd/yyyy

3. Parent/Guardian/Individual of Record:______________________________
 Last Name First Name MI

4. Provider's/Clinic's Name: ______________________________________

5. To determine if a child (0 through 18 years of age) is eligible to receive state or federal vaccine through the TVFC Program, at each immunization encounter/visit enter the date and mark the appropriate eligibility category. *If Column A-F is marked, <u>the child is eligible for the TVFC Program</u>. If column G is marked the child is not eligible for TVFC Program.*

	Eligible for VFC Vaccine				State Eligible		Not Eligible
	A	B	C	D	E	F	G
Date	**Medicaid Enrolled**	**No Health Insurance**	**American Indian or Alaskan Native**	***Underinsured served by FQHC, RHC or deputized provider**	****Enrolled in CHIP**	*****Other underinsured**	**Has health insurance that covers vaccines**
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**Underinsured includes children with health insurance that does not include vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance. In addition, to receive VFC vaccine, underinsured children must be vaccinated through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) or under an approved deputized provider. The deputized provider must have a written agreement with an FQHC/RHC and the state/local/territorial immunization program in order to vaccinate underinsured children.*
***Children enrolled in separate state Children's Health Insurance Program (CHIP). These children are considered insured and are eligible for vaccines through the TVFC program as long as the provider bills CHIP for the administration of the vaccine.*
**** Other underinsured are children that are underinsured but are not eligible to receive federal vaccine through the VFC program because the provider or facility is not a FQHC/RHC or a deputized provider. However, these children may be served if vaccines are provided by the state program to cover these non-VFC eligible children.*

TEXAS Department of State Health Services

Stock No. C-10
03/2014

Texas Vaccines For Children (TVFC) Program
Patient Eligibility Screening Record

(Continued)

	Eligible for VFC Vaccine				State Eligible		Not Eligible
	A	**B**	**C**	**D**	**E**	**F**	**G**
Date	**Medicaid Enrolled**	**No Health Insurance**	**American Indian or Alaskan Native**	***Underinsured served by FQHC, RHC or deputized provider**	****Enrolled in CHIP**	*****Other underinsured**	**Has health insurance that covers vaccines**
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Medicaid:

Medicaid Number: ________________________________

Date of Eligibility: ________________________________

CHIP:

CHIP Number: ________________________________

Group Number: ________________________________

Date of Eligibility: ______________________________

Private Insurance:

Name of Insurer: ______________________________

Insurer Contact Number: _______________________

Insurance Name: ______________________________

Policy/Subscriber Number: ______________________

TEXAS Department of State Health Services

Stock No. C-10
03/2014

Questions About Your Child and Tuberculosis (TB)

Child's Name _____ Date of Birth _____

Your Name_____

Today's Date_____

We need your help to find out if your child has been exposed to the disease tuberculosis, also known as TB.

TB is caused by germs. It is usually spread to another person by coughing or sneezing. A person can have TB germs in their body but not have active TB disease. TB can be prevented and treated. Your answers to the questions below will let us know if your child might have been exposed to TB. If your answers show your child might have picked up the TB germs, we will want to give him or her a TB skin test. The skin test is not a vaccination. It will not prevent TB. It will only let us know if your child has the TB germs.

Check the box that matches your answer:	Yes	No	Do Not Know
1. Has your child been tested for TB? If yes, when? Please tell us the date _____			
2. Have you ever been told that your child had a positive TB skin test (TST)? If yes, when? Please tell us the date _____			
3. TB can cause fever that can last days or weeks. It can cause weight loss, a bad cough (lasting over two weeks), or coughing up blood.			
Has your child been around anyone with any of these problems?			
Has your child been around anyone sick with TB?			
Has your child ever had any of these problems or do they have them now?			
4. Was your child born in another part of the world like Mexico or Latin America, the Caribbean, Africa, Eastern Europe, or Asia?			
5. Has your child been to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe, or Asia for more than 3 weeks? Which country or countries did your child visit? _____			
6. Do you know if your child has spent more than 3 weeks with anyone who:			
Uses needles for drug use?			
Has AIDS?			
Was or is in jail or prison?			
Has just come to the United States from another country?			

FOR THE PROVIDER:
If the prior test was negative and the answer to #4 is yes, the child does not need a repeat skin test.
If the prior test was negative and occurred at least 8 weeks after the situation described in #3a, 3b, 5, or 6, the child does not need a repeat skin test.
If the prior test was positive, the child does not need a repeat skin test; but a positive answer to #3c would indicate a chest x-ray as soon as possible.

PPD administered Yes___ No___
If yes,
Date administered ____/____/____ Date read ____/____/____ PPD response_____ mm

PPD provider _____ _____
Signature Printed Name
If chest x-ray done, date and results
_____

Provider phone number_____City_____County_____

If positive, referral to local/regional health department/specialist? Yes___ No___
If yes, name of health dept/specialist _____

Contact your local or regional health department if assistance is needed.

Patient name: _____ Date of birth: ____/____/____ (mo.) (day) (yr.)

Screening Checklist for Contraindications to Vaccines for Children and Teens

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 weaken their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, 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 child's 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.

Technical content reviewed by the Centers for Disease Control and Prevention

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

www.immunize.org/catg.d/p4060.pdf ▪ Item #P4060 (1/15)

TEXAS Department of State Health Services

Risk Assessment for Lead Exposure: Parent Questionnaire

Form Pb - 110

Healthcare Provider: For children less than 6 years of age, complete a blood lead test at any first checkup after age 12 and 24 months if there is no evidence of a previous blood lead test.

Patient's Name:	DOB:	Medicaid #:
Provider's Name:	Administered by:	Date:

Parent Questionnaire

		Yes	Don't know	No
1	Does your child live in or visit a home, daycare or other building built before 1978?			
2	Does your child live in or visit a home, daycare or other building with ongoing repairs or remodeling?			
3	Does your child eat or chew on non-food things like paint chips or dirt?			
4	Does your child have a family member or friend who has or did have an elevated blood lead level?			
5	Is your child a newly arrived refugee or foreign adoptee?			
6	Is your child exposed to any of the following (if YES, check all that apply):			

If "Yes" or "Don't Know" Perform a Blood Lead Test

Contamination from a parent, relative, or friend with jobs or hobbies like these?

- ☐ Radiator repair
- ☐ Pottery making
- ☐ Lead smelting
- ☐ Welding
- ☐ Making fishing weights
- ☐ House construction or repair
- ☐ Battery manufacture or repair
- ☐ Burning lead-painted wood
- ☐ Automotive repair shop or junkyard
- ☐ Going to a firing range or reloading bullets
- ☐ Chemical preparation
- ☐ Valve and pipe fittings
- ☐ Brass/copper foundry
- ☐ Refinishing furniture
- ☐ Other:

Sources of lead in food and remedies?

- ☐ Imported or glazed pottery such as a Mexican bean pot
- ☐ Imported candy, (like Chaca Chaca) especially from Mexico
- ☐ Nutritional pills other than vitamins
- ☐ Other:
- ☐ Foods canned or packaged outside the U.S.
- ☐ Remedies such as greta, azarcón, alarcón, alkohl, bali goli, coral, ghasard, liga, pay-loo-ah, rueda

Cuestionario de Padre

		Sí	No lo se	No
1	¿Vive su hijo(a) o visita una casa, centro de guardería u otro edificio construida antes de 1978?			
2	¿Vive su hijo(a) o visita una casa, centro de guardería u otro edificio que está siendo pintada, remodelada, o en la que están pelando o lijando la pintura?			
3	¿Su hijo(a) come o mastica cosas que no son comida, como pedazos de pintura o tierra?			
4	¿Tienen parientes o compañeros de su hijo(a) que tienen o tuvieron altos niveles de plomo en la sangre?			
5	¿Es su hijo recién refugiado o adoptado del extranjero?			
6	¿Ha sido expuesto su hijo(a) a cualquier de los siguientes? (si SÍ, marque todos que apliquen):			

Si "sí" o "no lo se" Le haga al niño una prueba de plomo en el sangre

Contaminación de un padre, pariente, o amigo con trabajos o pasatiempos como estas?

- ☐ Reparación de radiadores
- ☐ Fabricación de cerámica
- ☐ Industria del plomo
- ☐ Soldadura
- ☐ Fabricación de pesas para pescar
- ☐ Construción o reparación de casas
- ☐ Fabricación o reparación de baterías
- ☐ Quema de madera pintada con plomo
- ☐ Taller mecánico para autos o lote de chatarra
- ☐ Ir a un campo de tiro o recargar balas
- ☐ Preparación de químicos
- ☐ Partes sueltas para tubos de cañerías y válvulas
- ☐ Fundición de latón/cobre
- ☐ Terminado de muebles
- ☐ Otros:

Fuentes de plomo en comidas y remedios?

- ☐ Productos de cerámica importada o con recubrimiento de barniz, como una olla para frijoles de México
- ☐ Productos enlatados o empacados fuera de los Estados Unidos
- ☐ Dulces importados, (como Chaca Chaca) especialmente de México
- ☐ Remedios tradicionales como greta, azarcón, alarcón, alkohl, bali goli, coral, ghasard, liga, pay-loo-ah, rueda
- ☐ Píldoras alimenticias con excepción de las vitaminas
- ☐ Otros:

Fax completed form to 512-458-7699, or mail to the address below.

Texas Childhood Lead Poisoning Prevention Program
PO BOX 149347 • Austin, TX 78714-9347 • 1-800-588-1248 • www.dshs.state.tx.us/lead

Revised 03/14/11