

PATIENT ELIGIBILITY SCREENING RECORD
PENNSYLVANIA DEPARTMENT OF HEALTH
VACCINES FOR CHILDREN (VFC) PROGRAM

DATE _____
FECHA

CHILD _____
NINO/NINA

DATE OF BIRTH _____
FECHA DE NACIMIENTO

**PARENT/GUARDIAN
INDIVIDUAL OF
RECORD** _____
NOMBRE DE PARENTE **LAST/APELLIDO** **FIRST/NOMBRE** **MI/INICIAL**

PROVIDER _____
NOMBRE DE MEDICO

A RECORD MUST BE KEPT IN THE HEALTHCARE PROVIDER'S OFFICE THAT REFLECTS THE STATUS OF CHILDREN 18 YEARS OF AGE OR YOUNGER WHO RECEIVE IMMUNIZATIONS THROUGH THE VFC PROGRAM. THE RECORD MAY BE COMPLETED BY THE PARENT, GUARDIAN, OR INDIVIDUAL OF RECORD, OR BY THE HEALTHCARE PROVIDER. THE SAME RECORD MAY BE USED FOR ALL SUBSEQUENT VISITS AS LONG AS THE CHILD'S ELIGIBILITY STATUS HAS NOT CHANGED. WHILE VERIFICATION OF ELIGIBILITY STATUS IS NOT REQUIRED, THE PROVIDER MUST RETAIN THIS OR A SIMILAR RECORD FOR EACH CHILD RECEIVING THE VACCINE.

EN CADA OFICINA DE MEDICOS, SE MANTIENE UN ARCHIVO DE NINO 18 ANOS O MENOS QUE RECIBEN VACUNAS POR EL PROGRAMA VFC. ESTE RECORD PUEDE SER LLENADO POR EL PACIENTE, GUARDIAN, INDIVIDUAL DEL ARCHIVO O POR EL MEDICO PRIVADO. EL MISMO ARCHIVO SE USARA PARA TODAS VISITAS MIENTRAS LA ELIGIBILIDAD DE SEGURO NO HA CAMBIADO. MIENTRAS LA ELIGIBILIDAD DE EL SEGURO NO ES REQUERIDO, EL MEDICO TENDRA EL ARCHIVO PARA CADA NINO RECIBIENDO VACUNAS.

THIS CHILD QUALIFIES FOR VACCINATION THROUGH THE VFC PROGRAM BECAUSE HE/SHE:
ESTE NINO/NINA QUALIFICA PARA VACUNAS POR EL PROGRAMA DE VFC PORQUE:
CHECK ONE/MARQUE UNO

_____ **ENROLLED IN MEDICAL ASSISTANCE INCLUDING MA MC**
ASISTENCIA PUBLICA

_____ **DOES NOT HAVE HEALTH INSURANCE**
NO TIENE SEGURO MEDICO

_____ **AMERICAN INDIAN OR ALASKAN NATIVE**
INDIO AMERICANO O NATIVE DE ALASKA

_____ **HEALTH INSURANCE DOES NOT COVER VACCINES (APPLICABLE TO FQHC/RHC)**
TIENE SEGURO MEDICO QUE NO CUBRE VACUNAS

THIS FORM MAY BE COPIED AS NEEDED. FOR ADDITIONAL FORMS, CONTACT:
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CFC PROGRAM
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