BILLING & SCREENING SHEET PEDIATRIC

Effective: May, 20 2022

118 Cross Creek Blvd., Salem IL 62881 618-548-3878

Last Name	First Name	MI	Date

Address	City	Zip

Phone	Sex M F	Weight	Doctor

Birthdate	Age	Previous Name

Screening Checklist for Contraindications to Vaccines for Infants, 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 health care provider to explain it.

		YES	NO	Unknown
1.	Is the patient sick today?			
2.	Does the patient have allergies to medications, food, a vaccine component, or latex?			
3.	Has the patient had a serious reaction to a vaccine in the past?			
4.	Has the patient 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 patient to be vaccinated is 2 through 4 years of age, has a health care provider told you that the child had wheezing or asthma in the past 12 months?			
6.	If the patient is a baby, have you ever been told he/she has had intussusception?			
7.	Has the patient, a sibling, or a parent had a seizure; has the patient had a brain or other nervous system problems?			
8.	Does the patient have cancer, leukemia, HIV/AIDS, or any other immune system problem?			
9.	In the past 1-3 months, has the patient 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 patient received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?			
11.	Is the patient pregnant or is there a chance she could become pregnant during the next month?			
12.	Has the patient received any vaccinations in the past 4 weeks?			

If services will be billed, I authorize Marion County Health Department to release service related information regarding the above mentioned to third party payers and to bill for services rendered to patient if applicable and to the inclusion of service data into the I Care & Cornerstone data base. I request my payer to pay MCHD directly for services rendered to patient. I understand I am responsible for payment in the event my third party payer determines I am ineligible for this benefit.

FORM COMPLETED BY: _____ RELATIONSHIP: _____ DATE: _____
(PARENT OR GUARDIAN)

FORM REVIEWED & IMMUNIZATIONS GIVEN BY: _____ DATE: _____
(NURSE)

FOR OFFICE USE ONLY

	PAYOR SOURCE		AMOUNT PAID		VACCINE SERVICE
	Medicaid		$		VFC
	Managed Care (MCO)		Check		Title 19 (XIX)
	Molina		Cash		No Insurance
	Meridian		Receipt #:		Underinsured
	B/C Community Health Plan				CHIP Title 21 (XXI) or State Funded
	Aetna Better Choice		Debit/Credit Card		PP
	Youth Care		TRANS#		Private Insurance
	Private Insurance				OTHER: TB TB Assessment
	Name:				OTHER: LEAD (C V) Lead Assessment HGB