Pediatric Services Screening/Billing Form

☐ Salem Location: 118 Cross Creek Blvd. Salem, IL 62881 Phone:618-548-3878 ☐ Centralia Location: 1013 N Poplar Centralia, IL 62801 Phone : 618-532-6518

Last Name	First Name	MI	Date
Address		City	Zip
Phone	Sex M F	Weight	Doctor
Birthdate	Age	Previous Name	

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 the vaccination staff to explain it.	YES	NO	Don't Know
Is the child sick today?			
Does the child have allergies to medications, food, a vaccine component, or latex?			
Has the child had a serious reaction to a vaccine in the past?			
Does the child have a long-term health problem with heart, lungs (including asthma), kidney, liver, nervous system, or metabolic disease (e.g., diabetes), a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are they taking regular aspirin or salicylate medication?			
For children aged 2 through 4 years, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?			
For babies, have you ever been told he/she has had intussusception?			
Has the child, a sibling, or a parent had a seizure; has the patient had a brain or other nervous system problems?			
Has the child ever been diagnosed with a heart condition (myocarditis or pericarditis) or have they had Multisystem Inflammatory Syndrome (MIS-C) after an infection with the virus that causes COVID-19?			
Does the child have an immune-system problem such as cancer, leukemia, HIV/AIDS?			
In the past 6 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs to treat rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?			
Does the child's parent or sibling have an immune system problem?			
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?			
Is the child/teen pregnant or is there a chance she could become pregnant during the next month?			
Has the child received any vaccinations in the past 4 weeks?			
Has the child ever felt dizzy or faint before, during, or after a shot?			
Is the child anxious about getting a shot today?			

If services are billed, I authorize Marion County Health Department (MCHD) to release service-related information regarding the above-mentioned to third-party payers and to bill for services rendered to the patient if applicable. I request my payer to pay MCHD directly for services rendered to the patient. **I understand I am responsible for payment in the event my third-party payer determines I am ineligible for this benefit.** By signing this form below, I acknowledge the following and certify that: I am the parent or legal guardian of the child, or I am authorized to consent for vaccination for the child named above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the requested vaccine(s) and I have received, read and/or had explained to me the appropriate information sheet(s) for the vaccine(s) I have elected. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. I attest that my answers on the screening form are truthful and accurate. I acknowledge that I should remain near the vaccination location for approximately 15 minutes after vaccine administration. I authorize the data on this form to be released to I-CARE IIS database. I acknowledge the offering and/or receipt of the Notice of Privacy Practices. I fully understand all the risks and benefits of this child receiving vaccine(s) and consent to the administration.

SIGNATURE OF PARENT OR GUARDIAN: _____ DATE: _____

FORM REVIEWED & IMMUNIZATIONS GIVEN BY NURSE: _____DATE: _____

OFFICE USE ONLY BELOW THIS LINE

	PAYOR SOURCE		AMOUNT PAID		VACCINE SERVICE
	Medicaid		$		VFC Vaccine
	Managed Care (MCO)		**Check**		PP Vaccine
	Molina		**Cash**		OTHER: TB Test TB Assessment
	Meridian		**Receipt #:**		
	B/C Community Health Plan				OTHER: LEAD -Capillary Lead Assessment HGB
	Aetna Better Choice		**Debit/Credit Card**		
	Youth Care		**TRANS#**		
	Private Insurance				
	Name:				

PLEASE ATTACH A COPY OF ANY/ALL INSURANCE CARDS

Updated: February 5th 2025