Patient Eligibility Screening/Release of Vaccination Information

Vaccines for Children Program *AZ State Immunization Information System*

Today's Date: _____

Child's Name: _____ DOB: _____

Parent/Guardian Name: _____

This child qualifies for vaccinations through the VFC program because he/she:

(CHECK ONLY ONE)

☐ Is enrolled in AHCCCS and **DOES NOT** have Private Insurance

☐ Is American Indian or Alaskan Native

☐ Is enrolled in KidsCare

☐ Does not have health insurance

-OR-

This child DOES NOT qualify for vaccinations through the VFC program because he/she:

☐ Has **Private** health insurance

Please be advised, if your insurance company does not cover immunizations and you do not let us know at the time of the visit, it is your responsibility to pay the cost involved. VFC policy dictates who is eligible for VFC vaccines. More information is available on the Arizona Department of Health Services website: http://www.azdhs.gov/phs/immunization/vaccine-policy-changes.htm. If you are unsure if immunizations and well check-ups are covered, please contact your insurance company.

"I agree to allow the health care provider giving vaccinations to release information about all vaccinations given to the person for whom I am authorized to consent, to the Arizona State Immunization Information System (ASIIS), other health care providers and schools in order to avoid receiving unnecessary vaccinations and to provide information about what immunizations have been received. I understand that I am not required to agree to the release of this information in order to receive the vaccinations I request."

"If I do not wish this record to be included in ASIIS, I have the option of crossing out the above statement and initialing it."

I acknowledge that the above statements apply and are true until revoked by me in writing.

Signature: _____ Date: _____ Witness Initials _____

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