DETROIT HEALTH DEPARTMENT VISIT VISIT CHILD FACE SHEET IMMUNIZATION (PLEASE PRINT)

PATIENT'S LAST NAME	FIRST NAME	MIDDLE INTIAL	DATE OF BIRTH	AGE	SEX

STREET ADDRESS	CITY	ZIP CODE	PHONE

PARENT/GUARDIAN	DATE OF BIRTH	PREFERRED CONTACT METHOD: ☐ PHONE ☐ EMAIL EMAIL ADDRESS:

SCREENING QUESTIONS *Please respond to the following questions to the bet of your ability*	YES	NO
1. Do you have questions about the vaccinations your child is receiving today?		
2. Is your child sick today?		
3. Is your child allergic to any medications, foods, vaccine components or latex?		
4. Has your child ever had a serious reaction after getting a vaccine?		
5. Does your child have health problems with their lungs, heart or kidney?		
6. Does your child have a metabolic disease (e.g., diabetes), asthma, or a blood disorder (e.g., sickle cell)? Is your child on long term asthma therapy?		
7. Has your child or their siblings ever has a seizure? Has the child's parent ever had a seizure?		
8. Does your child have health problems with their brain or nervous system?		
9. Does your child have cancer, leukemia, HIV/AIDS, or any other immune system problem?		
10. In the past 3 months, has your child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?		
11. In the past year, has your child received a blood transfusion, blood products, or been given immune (gamma) globulin or an antiviral drug?		
12. Is your child pregnant? Is there a chance your child could become pregnant during the next month? Are you pregnant and or breastfeeding?		
13. Has your child received vaccinations in the past 4 weeks?		
14. Has your child received a TB skin test this month?		
15. Has your child ever had Guillain-Barré syndrome?		
16. Are you currently pregnant?		
17. Do you have a child under 5 years of age?		
18. Are you currently receiving WIC benefits? Are you interested in applying?		

Screening Assessment derived from IAC screening guidelines (9/18)

I, the parent/guardian, hereby certify that the above information is true and correct to the best of my knowledge.

Name: _____ Signature: _____ Date: _____

FOR ADMINISTRATIVE USE ONLY

HEALTH INSURANCE NAME	HEALTH INSURANCE NUMBER	MCIR ID

NOTES: _____

_____

Intake Staff Signature _____ ☐ **Lead Test** ☐ **Refused Lead Test** ☐ **WIC Referral**

For Clinic Use Only:

Please circle client's eligibility status.

Client Eligibility Status: **M** = Medicaid **U** = Uninsured **N** = American Indian/Alaska Native **D** = Underinsured **P** = Private Insurance

Site Code: **1** = Left Arm, **2** = Right Arm, **3** = Left Thigh, **4** = Right Thigh

Route Code: **O** = Oral, **IM** = Intramuscular, **SC** = Subcutaneous

If VIS given on date other than the date vaccine was administered, record date in "Notes" section.

Vaccine	Give	Dose #	Site	Route	MFR	MFR Lot #	VIS Date
DTaP					GSK SP		
Td					SP SP		
Tdap					GSK SP		
Hib					Merck		
Polio/IPV					SP		
MMR					Merck		
Hepatitis B Pediatric					GSK Merck		
Varicella					Merck		
Rotavirus					Merck		
Hepatitis A Pediatric					GSK Merck		
Influenza (S / M)					SP		
Influenza 6-35 months (S / M)					SP		
PCV13					Wyeth		
MenACWY					SP GSK		
MenB					Novartis		
HPV					SP		
PPSV23					Merck		
Other:							
COMBINATION VACCINES							
DTaP-IPV/**Hib**					SP		
DtaP-IPV-**HepB**					GSK		
MMRV					Merck		
DTaP-IPV					SP		

Signature: _____

Date Dose(s) & VIS Given*: _____

Notes: _____

_____

MCIR ENTRY PERSON: _____

DETROIT HEALTH DEPARTMENT VISIT ADULT FACE SHEET IMMUNIZATION (PLEASE PRINT)

PATIENT'S LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH	AGE	SEX

STREET ADDRESS	CITY	ZIP CODE	PHONE

PREFERRED CONTACT METHOD: ☐ PHONE ☐ EMAIL EMAIL ADDRESS:

SCREENING QUESTIONS *Please respond to the following questions to the best of your ability.*	YES	NO
1. Do you have questions about the vaccinations you are receiving today?		
2. Are you sick today?		
3. Are you allergic to any medications, foods, vaccine components or latex?		
4. Have you ever had a serious reaction after getting a vaccine?		
5. Do you have health problems with your lungs, heart or kidney?		
6. Do you have a metabolic disease (e.g., diabetes), asthma, or a blood disorder (e.g., sickle cell)? Are you on long term aspirin therapy?		
7. Have you ever had a seizure? Have your siblings or parents ever had seizures?		
8. Do you have health problems with your brain or nervous system?		
9. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?		
10. In the past 3 months, have you 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?		
11. In the past year, have you received a blood transfusion, blood products, or been given immune (gamma) globulin or an antiviral drug?		
12. Are you pregnant? Is there a chance you could become pregnant during the next month?		
13. Have you received vaccinations in the past 4 weeks?		
14. Have you received a TB skin test this month?		
15. Are you currently pregnant or breastfeeding?		
16. Do you have a child under 5 years of age?		
17. Are you currently receiving WIC benefits? Are you interested in applying?		

Screening Assessment derived from IAC screening guidelines (9/18).

I hereby certify that the above information is true and correct as to the best of my knowledge.

Name: _____ Signature: _____ Date: _____

FOR ADMINISTRATIVE USE ONLY

HEALTH INSURANCE NAME	HEALTH INSURANCE NUMBER	MCIR ID

Notes: _____

Intake Staff Signature _____ ☐ WIC Referral

FOR CLINIC USE ONLY: Please circle client's eligibility status.

Please circle client's eligibility status. **A** = MI-AVP **P** = Private Insurance

▪ Site Code: **1** = Left Arm, **2** = Right Arm, **3** = Left Thigh, **4** = Right Thigh,
Route Code: **O** = Oral, **IM** = Intramuscular, **SC** = Subcutaneous
* If VIS given on date other than the date vaccine was administered, record date in "Notes" section.

Vaccine	Give	Eligibility Status▪	Dose #	Site▪	Route	Single/ Multi	MFR	MFR Lot#	VIS Date
Td							SP SP		
Tdap							GSK SP		
Hib**		P					Merck		
MMR							Merck		
Hepatitis B Pediatric (19 years & under)							GSK Merck		
Hepatitis B Adult							GSK Merck		
Varicella		P					Merck		
Hepatitis A Adult							GSK Merck		
Influenza		P							
PCV13							Wyeth		
PPSV23							Merck		
MenACWY**		P					SP GSK		
MenB		P					Novartis		
HPV							Merck		
RZV							GSK		
Other:									

**Only for medical indications in adults. Review CDC Immunization Schedule and DHD Standing Orders.

To receive MI-AVP vaccine, client must meet all age, insurance, and risk criteria as outlined in the VFC Resource Book. Document client eligibility in the notes section.

Signature: _____

Date Dose(s) & VIS Given*: _____

Notes: _____

MCIR ENTRY PERSON: _____