JASPER COUNTY HEALTH DEPARTMENT– IOWA

Children Immunizations- VFC

Name:	Date of Birth:
Address:	
Phone Number: Text: Y or N	Email:
Places Immunizations Received:	Primary Dr.:

The following questions will help us determine which vaccines your child may be given today.	Yes	No	Unsure
1. Is the child sick today?			
2. Does the child have allergies to medicine, food, a vaccine component, or latex?			
3. Has the child had a serious reaction to a vaccine in the past?			
4. Does the child have a long-term health problem with heart, lung (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?			
5. For Age: 2-4. Has a medical provider told you that the child had wheezing or asthma in the past year?			
6. For babies: Have you ever been told the child had intussusception?			
7. Has the child, a sibling, or a parent had a seizure; child had a brain or other nervous system problem?			
8. 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?			
9. Does the child have an immune-system problem such as cancer, leukemia, HIV/AIDS?			
10. In the past 6 months, has the child taken medications that affect the immune system such as steroids, or anticancer drugs; rheumatoid arthritis drugs, Crohn's disease, or psoriasis; or had radiation treatments?			
11. Does the child's parent or sibling have an immune system problem?			
12. In the past year, has the child received immune globulin, blood products, or an antiviral drug?			
13. Is the child/teen pregnant?			
14. Has the child received vaccinations in the past 4 weeks?			
15. Has the child ever felt dizzy or faint before, during, or after a shot?			
16. Is the child anxious about getting a shot today?			

I have received VIS forms. I understand the risks and I give permission to administer immunizations.
Parent or Guardian's Signature: _____ Date: _____

*** FOR OFFICE USE ONLY ***

	Pediarix	Hib	Prevnar 20	Kinrix	MMRV	MMR	Varicella	COVID	Flu	RSV
VIS Date	7/24/23	8/6/21	5/12/23	7/24/23	8/6/21	8/6/21	8/6/2021	10/19/23	8/6/21	10/19/23
Lot/Exp.										
Site										
	DTaP	Polio	Hep A	Hep B	Tdap/Td	HPV	Men ACWY	Men B	Rotavirus	
VIS Date	8/6/21	8/6/21	10/15/21	5/12/23	8/6/21	8/6/21	8/6/21	8/6/21	10/15/21	
Lot/Exp.										
Site										

Nurse's Signature: Date:

□ **VFC Eligibility Completed** □ **Entered in IRIS** □ **Scanned** Next Immunization Due:
Notes: