2mth. 4mth. 6mth. 12mth, 15mth

NURSE'S INITIALS: ________

If you have private insurance and your child receives vaccines here at our office, it is your responsibility to contact your insurance company to obtain this information

If your insurance plan does NOT cover vaccines, or only covers a certain amount, we offer vaccines that are provided to us by the state (Vaccines For Children). You are not charged for the vaccine, but you are charged an administration fee of ***$21.93*** per vaccine given. This amount is due in full at the time of service.

ELIGIBILITY CRITERIA FOR VFC VACCINES

1. Medicaid eligible: A child who is eligible for a Medicaid program.
2. Uninsured: A child who has no health insurance coverage.
3. American Indian or Alaskan Native: As defined by the Indian Health Care Improvement Act.
4. Underinsured: A child who has commercial (private) health insurance but the coverage does not include vaccines, whose insurance covers only selected vaccines (VFC-eligible for non-covered vaccines only), or a child whose insurance caps vaccines coverage at a certain amount. Once that coverage amount is reached, the child is categorized as underinsured.

Children whose health insurance covers the cost of vaccinations are not eligible for VFC Vaccines, even when a claim for the cost of the vaccine and it's administration would be denied for payment by the insurance carrier because the plan's deductible had not been met.

If your child receives vaccines and their Medicaid was inactive and/or was not presented at the time of service, but later becomes retroactive, you will be responsible for payment for those vaccines in full.

Please choose which vaccines you will receive today:

PRIVATE or **VFC**

(Please circle one)

Child's Name:______________________________ Child's DOB:____________

Guardian's Name (Please PRINT):________________ Relationship:____________

Guardian's Signature: ________________________ Date: ______________

Your child will receive the circled vaccines today. Please review the Vaccine Information Sheets located in the exam room.
If you have any questions, please ask the doctor or nurse.

Hepatitis B	Rotavirus	DTaP	Tdap
Hib	PCV13	IPV	FluMist
Flu Injection	MMR	Varicella	Hepatitis A
	HPV	MCV4	

Child's Name:__________________________ **Date of Birth:**____________

Division of Public Health,
Prevention Services Branch
Tuberculosis Program
404-657-2634 fax: 404-463-3460
http://health.state.ga.us/programs/tb

Tuberculosis (TB) Risk Assessment

Child Health Services

Circle Yes or No.

1.	Is the child in close contact to a person sick with active TB disease? *	Yes	No
2.	Does the child have or is at risk to have HIV?	Yes	No
3.	Was the child or the child's parent born outside the US?	Yes	No
4.	Is the child exposed to a person in jail or a person who has been in jail in the past five years?	Yes	No
5.	Is the child exposed to a person who has HIV, who is homeless or who lives in a nursing home or another group home?	Yes	No
6.	Is the child exposed to drug users or migrant farm workers?	Yes	No
7.	Does the child have a health problem that lowers the immune system?	Yes	No
8.	Does the child live in a community that has a high risk for TB?	Yes	No
9.	Has the child traveled to or had a visitor from any foreign country since the last visit?	Yes	No
10.	Does the child have any symptoms of TB (cough, fever, night sweats, loss of appetite, weight loss, or fatigue) or an abnormal chest x-ray?*	Yes	No

** Call the Health Department*

* THIS FORM IS TWO-SIDED! →

*Any **'yes'** answer means the child is High Risk and should have a Mantoux TB skin test. The test should be read by a Health Professional.*

For your child's health, this form is required to be completed at the following visits:

1 month **6 month** **12 month** **18 month**

2 year through 18 year

DPH06/057W Rev. 08.2006

Child's Name:______________________ Date of Birth:__________

Georgia Department of Human Resources (DHR)
Division of Public Health

Georgia Department of Human Resources
Georgia Childhood Lead Poisoning Prevention Program
Lead Risk Assessment Questionnaire

1. Does your child live in or often visit a house that may have been built before 1978?
2. Does your child live in or often visit a house that is being remodeled or is having paint removed?
3. Does your child live with or often visit another child that has an elevated blood lead level?
4. Does your child live with anyone that works at a job where lead may be found or has a hobby that uses lead?
5. Does your child chew on or eat non-food items like paint chips or dirt
6. Does your child live near an active lead smelter, battery recycling plant, or other industry likely to release lead?
7. Does your child receive medicines such as *greta, azarcon, kohl, or pay-loo-ah*?

When using the questionnaire, blood lead tests should be done immediately if the child is at high risk (one or more "yes" or "I don't know" answers on the risk assessment questionnaire) for lead exposure.

For your child's health, this form is required to be completed at the following visits:

6 month **9 month** **18 month**

3 year **4 year** **5 year** **6 year**

2 Peachtree Street NW • 15th Floor • Atlanta, Georgia 30303-3142
404-657-2700 • FAX: 404-657-2715
http://health.state.ga.us