COUNTY OF SUFFOLK

STEVEN BELLONE
SUFFOLK COUNTY EXECUTIVE

DEPARTMENT OF HEALTH SERVICES

GREGSON H. PIGOTT, MD, MPH
Commissioner

Nombre de Paciente: _____
Fecha de Nacimiento _____ Sexo _____
Dirección _____
(Numero Y Calle)
_____
(Cuidad) (Estado) (Codigo Postal)
Numero de Teléfono _____
Nombre de Padres _____
Apellido de soltera de madre _____

Fecha de hoy: _____

Do Not Write Below This Line
OFFICE USE ONLY

	Si	No
1. ¿Esta su niño bien de salud hoy?		
2. ¿Ha estado su niño enferma durante la semana pasada?		
3. ¿Ha recibido su niño algunas vacunas contra una vacuna los pasados 28 dias?		
4. ¿Ha tenido su niño reaccion contra una vacuna?		
5. ¿Sufre su niña/niño de alguna enfermedad seria? (una enfermeda neuroliga, convulsion de fiebre, o enfermedad maligna).		
6. ¿Es su nino/nina alergico(a) a algunas substancia?		
7. ¿Ha recibido su niño sangre o injeccion de hemoglobulina en los pasados 12 meses?		
8. ¿Esta su niño tomando cortisona ó alguna medicina que baja la resistencia contra una infeccion?		
9. Para niñas solamente Fecha del ultima menstruacion _____ Esta o podria estar embarazada?		
10. Cuando fué la ultima vez que su nno visito un medico? Escriba la ultima fecha _____		
11. ¿Estan de acuerdo los padres ó representantes esperar 20 minutos depués que su niño hay a recibido las vacunas ?		
12. ¿Nombre de su seguro medico?		
13. ¿Cubre inmunizaciones su seguro medico ?		
14. En qué idioma prefiere la hoja de información sobre vacunas (vis)? _____		

Nurses Notes
Vaccines Aministered:
See medication sheet

Parent counseled regarding:

- ☐ Well Child Care and age appropriate CPE's
- ☐ Vaccination side effect and management
- ☐ Vaccine literature review with parent/ guardian
- ☐ Follow-up vaccination dates:
- ☐ Return on: _____
- ☐ No primary provider: Referred to FQHC

COMMENTS:

_____
(Nurse's signature)

Reviewed by Nursing _____

CHILD HEALTH – IMMUNIZATION PROGRAM
3500 Sunrise Highway, Ste. 124, PO Box 9006, Great River, NY 11739-9006
(631) 854-0222 | Fax (631) 854-0089

COUNTY OF SUFFOLK

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Name of Child_____

Date of Birth_____ Sex _____

Mailing Address_____
(Number & Street and/or P.O Box)

_____
(City & State)

Parent's Name_____

Telephone No._____

Child's mother's maiden name_____

Today's Date: _____

Do Not Write Below This Line

OFFICE USE ONLY

	Yes	No
1. Is your child well today?		
2. Has your child been sick within the past week? (sore throat, vomiting, fever, etc.)?		
3. Has your child received any immunizations within the past 28 days?		
4. Has your child ever had a reaction to a vaccine?		
5. Does your child have any serious illness (neurological disorder, ferile convulsions, malignacies)? If yes specify_____		
6. Is your child serverely allergic to latex, medication; or food?		
7. Has your child received a blood tranfusion or an injection of human immune serum globulin within the last 12 months?		
8. Is your child or anyone in your houshold receiving cortisone or any other drug which lowers resisitance to infection?		
9. For females only: Date of last period_____ Is or could your child be pregnant?		
10. When was the last time your child saw a doctor? Enter date: _____Name of provider:_____		
11. Parent/Guardian agrees to wait 20 minutes after child receives immunizations		
12. Name of Health Insurance?		
13. Does your health insurance cover immunizations?		
14. What language do you prefer vaccine information sheet (VIS)? _____		

Nurses Notes

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See medication sheet

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- ☐ Vaccine literature review with parent/ gaurdian
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COMMENTS:

_____
(Nurse's signature)

Reviewed by Nursing _____

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New York State Department of Health
Bureau of Immunization
Vaccines for the Vaccines for Children and Child Health Plus Programs

Patient Eligibility Screening Record

A record of all children 18 years of age or younger who receive immunizations through the Vaccines for Children (VFC) or Child Health Plus (CHPlus) programs must be kept in the health care provider's office. The record may be completed by the parent, guardian, individual of record, or by the health care provider. Eligibility screening and documentation must take place with each immunization visit to ensure the child's eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record of each child receiving vaccine.

Initial Screening Date: ____ / ____ / ____
MM DD YYYY

Child's Date of Birth: ____ / ____ / ____
MM DD YYYY

Child's Name: _____
Last Name First Name MI

Parent/Guardian/Individual of Record: _____
Last Name First Name MI

Is your facility a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC)? ☐ Yes ☒ No

Primary Provider's Name: SUF. CO. IMM. PROG.
Last Name First Name MI

Does this patient qualify for publicly purchased vaccines (check one box):

- ☐ Yes, is enrolled in Medicaid
- ☒ Yes, does not have health insurance
- ☐ Yes, is an American Indian or Alaska Native
- ☐ Yes, is under insured (has health insurance that does not pay for vaccinations)
- ☐ Yes, is enrolled in Child Health Plus (CHPlus)
- ☐ No, this child does not qualify for immunizations through the VFC program because he/she does not meet the eligibility criteria

Screen and document patient eligibility at each immunization visit (date and check one box below).

	Eligibility Status					
Date	Is enrolled in Medicaid	Does not have health insurance	Is an American Indian or Alaska Native	Is underinsured	Is enrolled in CHPlus	Does not meet eligibility criteria
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SUFFOLK COUNTY DEPARTMENT OF HEALTH SERVICES

Immunization Program

Parent/Guardian: _____

Address: _____

City: _____ Zip Code: _____

MAIL TO: SC Dept. of Health Services
Budget & Finance Support Services Unit
3500 Sunrise Hwy, Suite 124
P.O. Box 9006
Great River, NY 11739-9006

Date of Service	Patient's Name

Number of Vaccines	DESCRIPTION	TOTAL
	Immunization Administration (Under 19) $17.85	
	Immunization Administration (Age 19 and Older) $13.23	

◯ DTAP	◯ HEP B	◯ PEDIARIX	◯ MCV4-MENACTRA	
◯ Tdap	◯ HEP A	◯ HPV-9	◯ MCV4-MENVEO	
◯ Td	◯ PCV-13	◯ PENTACEL	◯ MEN B-BEXSERO	
◯ IPV	◯ VAR	◯ ROTAVIRUS	◯ MEN B-TRUMENBA	
◯ HIB	◯ FLU	◯ KINRIX	◯	
◯ MMR	◯ MMRV	◯	◯	

Make all checks or money orders payable to SC Dept. of Health Services

Any questions regarding this bill please call (631)854-0193.

TOTAL $

Parent/guardian was asked and stated that they were ☐ able ☒ unable to pay.

Suff. Co. Imm. Prog.

_____ Provider's Signature

_____ Date

Insurance Information

Insurance Company Name _____

Policy Number _____ Group Number _____

Claiming Address _____

_____

Patient's DOB _____ Sex _____

Patient's Telephone Number: _____

SUFFOLK COUNTY DEPARTMENT OF HEALTH SERVICES

NOTICE OF PRIVACY PRACTICES EFFECTIVE 4/14/03

Acknowledgement of Receipt

I acknowledge that I have been provided with a copy of the Suffolk County Department of Health Services, Notice of Privacy Practices which became effective on April 14, 2003.

By:_____(facility)

Signature: _____ Date:_____

Print Name: _____

SCDOHS - Immunization Program
3500 Sunrise Highway, Suite 124
P.o. Box 9006
Great River, NY 11739-9006

SUFFOLK COUNTY DEPARTMENT OF HEALTH SERVICES

NOTICE OF PRIVACY PRACTICES EFFECTIVE 4/14/03

AVISO DE PRACTICAS DE CONFIDENCIALIDAD EFECTIVO EL 14 DE ABRIL DE 2003

Prueba de Recibo

Yo he recibido el Aviso de Prácticas de Confidencialidad que están en efecto desde el 14 de abril de 2003.

Por:_____ (facilidad de salud)

Firma:_____ Fecha:_____

Escriba su Nombre en Letras de Molde:_____