Vaccines for Children (VFC) Program
Patient Eligibility Screening Record

Private Sector

Please Print or Type	Date:
Child Name Last: _____ First: _____ MI: _____	
Date of Birth: ____ / ____ / ____ Mth Day Yr	
Parent/Guardian Last: _____ First: _____ MI: _____	
Provider Name:	

☐ **The child named above qualifies for immunization through the VFC Program because he/she or his/her parent/guardian states the child is 18 years of age or younger and:**

Choose only one of the following. (Note: If a child meets two or more of the eligibility qualifications, choose the first one that applies.)

____1. **Is Child Health and Disability Prevention (CHDP) Program or Medi-Cal eligible; or**

____2. **Does not have private health insurance; or**

____3. **Is an American Indian or Alaskan Native.**

☐ **The child named above does not qualify for immunization through the VFC Program.** (This includes children who have health insurance, whether or not it pays for vaccines and **Healthy Families Program subscribers**.)

Notes

1. This form documents the VFC-eligibility status of the child named above.
2. This same form may be used for all of the child's subsequent visits provided the child's eligibility status does not change.
3. The health care provider must keep this record for the VFC-eligible child for no less than three (3) years and make it available to state or federal officials for inspection upon request. If this form is used for subsequent immunizations with VFC Program vaccines, the three year period begins on the date the child received his or her last VFC Program-provided vaccine. Retention of this record for a child not eligible for the VFC Program is optional.
4. This record may be completed by the patient (if he or she is an emancipated minor or 18 years of age), his or her parent or guardian or by the health care provider.
5. **Verification of responses is not required.**