SAINT JOHNS COUNTY HEALTH DEPARTMENT

Patient information:						
Date:	Time:		New Patient	Established Patient		
Last Name:		First:		Middle:		
Address:						
Telephone Num	ber:		Type: Cell – Hor	ne – Work - Other		
City:		State:	Zip Cod	e:		
Date of Birth:			(If under 18) Child's Pediatrician:			
Race:	Sex:	<u>M / F</u>	Primary	Language:		
Ethnicity:	□Hispanic/Latino	□Unknc	wn/Unreported	□Non-Hispanic/Latino		
Insurance Name	::	1	Name of Insured:			
Name of person bringing child: Relationship to child:						
	<u>PLI</u>	EASECHECK	(BELOWTHEREASON(S)	YOUAREHERE		
			Child Immunization			
			680 Form			
			Religious Exemption			
	Children's	s Immuniza	<u>itions</u> VFC Eligibility – F	Please Check Below:		
Enrolled in Med	dicaid:		American India	n or Alaskan Native:		
No Health Insur	rance:		Underinsured:			
Private Insuranc	e:					

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Screening ChecklistPATIENT NAMEfor ContraindicationsDATE OF BIRTH
month / day / yearto Vaccines for Children and Teens

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	know
1. Is the child sick today?			
2. Does the child have allergies to medications, 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 lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Is he/she on long-term aspirin therapy?			
5. If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?			
6. If your child is a baby, have you ever been told he or she has had intussusception?			
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?			
8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?			
9. Does the child have a parent, brother, or sister with an immune system problem?			
10. In the past 3 months, has the child 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, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?			
12. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?			
13. Has the child received vaccinations in the past 4 weeks?			
FORM COMPLETED BY	DATE_		
FORM REVIEWED BY	DATE_		
Did you bring your immunization record card with you? yes \Box no \Box			

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.

immunization action coalition



Information for Healthcare Professionals about the Screening Checklist for Contraindications to Vaccines (Children and Teens)

Are you interested in knowing why we included a certain question on the screening checklist? If so, read the information below. If you want to find out even more, consult the references in **Notes** below.

NOTE: For supporting documentation on the answers given below, go to the specific ACIP vaccine recommendation found at the following website: www.cdc.gov/vaccines/hcp/acip-recs/index.html

1. Is the child sick today? [all vaccines]

There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events. However, as a precaution with moderate or severe acute illness, all vaccines should be delayed until the illness has improved. Mild illnesses (such as otitis media, upper respiratory infections, and diarrhea) are NOT contraindications to vaccination. Do not withhold vaccination if a person is taking antibiotics.

2. Does the child have allergies to medications, food, a vaccine component, or latex? [all vaccines]

An anaphylactic reaction to latex is a contraindication to vaccines that contain latex as a component or as part of the packaging (e.g., vial stoppers, prefilled syringe plungers, prefilled syringe caps). If a person has anaphylaxis after eating gelatin, do not administer vaccines containing gelatin. A local reaction to a prior vaccine dose or vaccine component, including latex, is not a contraindication to a subsequent dose or vaccine containing that component. For information on vaccines supplied in vials or syringes containing latex, see www.cdc.gov/vaccines-pubs/ pinkbook/downloads/appendices/B/latex-table.pdf; for an extensive list of vaccine components, see www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2. pdf. People with egg allergy of any severity can receive any recommended influenza vaccine (i.e., any IIV, RIV, or LAIV) that is otherwise appropriate for the patient's age and health status. With the exception of ccIIV and RIV (which do not contain egg antigen), people with a history of severe allergic reaction to egg involving any symptom other than hives (e.g., angioedema, respiratory distress), or who required epinephrine or another emergency medical intervention, the vaccine should be administerad in a medical setting, such as a clinic, health department, or physician office; vaccine administration should be supervised by a healthcare provider who is able to recognize and manage severe allergic conditions.

- 3. Has the child had a serious reaction to a vaccine in the past? [all vaccines] History of anaphylactic reaction (see question 2) to a previous dose of vaccine or vaccine component is a contraindication for subsequent doses. History of encephalopathy within 7 days following DTP/DTaP is a contraindication for further doses of pertussis-containing vaccine. There are other adverse events that might have occurred following vaccination that constitute contraindications or precautions to future doses. Under normal circumstances, vaccines are deferred when a precaution is present. However, situations may arise when the benefit outweighs the risk (e.g., during a community pertussis outbreak).
- 4. Does the child have a long-term health problem with lung, heart, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Is he/she on long-term aspirin therapy? [MMR, MMRV, LAIV, VAR]

A history of thrombocytopenia or thrombocytopenic purpura is a precaution to MMR and MMRV vaccines. The safety of LAIV in children and teens with lung, heart, kidney, or metabolic disease (e.g., diabetes), or a blood disorder has not been established. These conditions, including asthma in children ages 5 years and older, should be considered precautions for the use of LAIV. Children with functional or anatomic asplenia, complement deficiency, cochlear implant, or CSF leak should not receive LAIV. Children on long-term aspirin therapy should not be given LAIV; instead, they should be given IIV. Children with CSF leak, anatomic or functional asplenia, or cochlear implant, or on long-term aspirin therapy should not be given LAIV; instead, they should be given IIV. Aspirin use is a precaution to VAR.

- 5. If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months? [LAIV] Children ages 2 through 4 years who have had a wheezing episode within the past 12 months should not be given LAIV. Instead, these children should be given IIV.
- 6. If your child is a baby, have you ever been told that he or she has had intussusception? [Rotavirus]

Infants who have a history of intussusception (i.e., the telescoping of one portion of the intestine into another) should not be given rotavirus vaccine.

7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problem? [DTaP, Td, Tdap, IIV, LAIV, MMRV]

DTaP and Tdap are contraindicated in children who have a history of encephalopathy within 7 days following DTP/DTaP. An unstable progressive neurologic problem is a precaution to the use of DTaP and Tdap. For children with stable neurologic disorders (including seizures) unrelated to vaccination, or for children with a family history of seizures, vaccinate as usual (exception: children with a personal or family [i.e., parent or sibling] history of seizures generally should not be vaccinated with MMRV; they should receive separate MMR and VAR vaccines). A history of Guillain-Barré syndrome (GBS) is a consideration with the following: 1) Td/Tdap: if GBS has occurred within 6 weeks of a tetanus-containing vaccine and decision is made to continue vaccination, give Tdap instead of Td if no history of prior Tdap;

NOTE: For summary information on contraindications and precautions to vaccines, go to the ACIP's General Best Practice Guidelines for Immunization at www.cdc.gov/ vaccines/hcp/acip-recs/general-recs/contraindications.html

2) Influenza vaccine (IIV, LAIV, or RIV): if GBS has occurred within 6 weeks of a prior influenza vaccination, vaccinate with IIV if at high risk for severe influenza complications.

8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem? [LAIV, MMR, MMRV, RV, VAR]

Live virus vaccines (e.g., MMR, MMRV, VAR, RV, LAIV) are usually contraindicated in immunocompromised children. However, there are exceptions. For example, MMR is recommended for asymptomatic HIV-infected children who do not have evidence of severe immunosuppression. Likewise, VAR should be considered for HIV-infected children age 12 months through 8 years with age-specific CD4+ T-lymphocyte percentage at 15% or greater, or for children age 9 years or older with CD4+ T-lymphocyte counts of greater than or equal to 200 cell/µL. VAR should be administered (if indicated) to persons with isolated humoral immunodeficiency. Immunosuppressed children should not receive LAIV. Infants who have been diagnosed with severe combined immunodeficiency (SCID) should not be given a live virus vaccine, including RV. Other forms of immunosuppression are a precaution, not a contraindication, to RV. For details, consult ACIP recommendations (see references in **Notes** above).

9. Does the child have a parent, brother, or sister with an immune system problem? [MMR, MMRV, VAR]

MMR, VAR, and MMRV vaccines should not be given to a child or teen with a family history of congenital or hereditary immunodeficiency in first-degree relatives (i.e., parents, siblings) unless the immune competence of the potential vaccine recipient has been clinically substantiated or verified by a laboratory.

10. In the past 3 months, has the child 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? [LAIV, MMR, MMRV, VAR]

Live virus vaccines (e.g., LAIV, MMR, MMRV, VAR) should be postponed until after chemotherapy or long-term high-dose steroid therapy has ended. For details and length of time to postpone, consult the ACIP statement. Some immune mediator and immune modulator drugs (especially the antitumor-necrosis factor agents adalimumab, infliximab, and etanercept) may be immunosuppressive. A comprehensive list of immunosuppressive immune modulators is available in CDC Health Information for International Travel (the "Yellow Book") available at wwwnc.cdc.gov/travel/yellowbook/2020/travelers-with-additional-considerations/immunocompromised-travelers. The use of live vaccines should be avoided in persons taking these drugs. To find specific vaccination schedules for stem cell transplant (bone marrow transplant) patients, see General Best Practice Guidelines for Immunization (referenced in **Notes** above). LAIV, when recommended, can be given only to healthy nonpregnant people ages 2 through 49 years.

- 11. In the past year, has the child received a transfusion of blood/blood products, or been given immune (gamma) globulin or an antiviral drug? [MMR, MMRV, LAIV, VAR] Certain live virus vaccines (e.g., MMR, MMRV, LAIV, VAR) may need to be deferred, depending on several variables. Consult the most current ACIP recommendations (referenced in Notes above) for the most current information on intervals between antiviral drugs, immune globulin or blood product administration and live virus vaccines.
- 12. Is the child/teen pregnant or is there a chance she could become pregnant during the next month? [HPV, IPV, LAIV, MenB, MMR, MMRV, VAR]

Live virus vaccines (e.g., MMR, MMRV, VAR, LAIV) are contraindicated one month before and during pregnancy because of the theoretical risk of virus transmission to the fetus. Sexually active young women who receive a live virus vaccine should be instructed to practice careful contraception for one month following receipt of the vaccine. On theoretical grounds, IPV and MenB should not be given during pregnancy; however, it may be given if there is a risk of exposure. IIV and Tdap are both recommended during pregnancy. HPV vaccine is not recommended during pregnancy.

 Has the child received vaccinations in the past 4 weeks? [LAIV, MMR, MMRV, VAR, yellow fever]

Children who were given either LAIV or an injectable live virus vaccine (e.g., MMR, MMRV, VAR, yellow fever) should wait 28 days before receiving another vaccination of this type (30 days for yellow fever vaccine). Inactivated vaccines may be given at the same time or at any spacing interval.

VACCINE ABBREVIATIONS

LAIV = Live attenuated influenza vaccine HPV = Human papillomavirus vaccine IIV = Inactivated influenza vaccine ccIIV - cell culture inactivated influenza vaccine IPV = Inactivated poliovirus vaccine MMR = Measles, mumps, and rubella vaccine MMRV = MMR+VAR vaccine RIV = Recombinant influenza vaccine RV = Rotavirus vaccine Td/Tdap = Tetanus, diphtheria, (acellular pertussis) vaccine VAR = Varicella vaccine

Immunization Action Coalition • Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org



INITIATION OF SERVICES

<u>PART I</u>

CLIENT-PROVIDER RELATIONSHIP CONSENT

Client Name:

Name of Agency: Florida Department of Health in St. Johns County

Agency Address: 200 San Sebastian View Suite 1322 St. Augustine, FL. 32084

I consent to entering into a client-provider relationship. I authorize Department of Health staff and their representatives to render routine health care. I understand routine health care is confidential and voluntary and may involve medical visits including obtaining medical history, assessment, examination, administration of medication, laboratory tests and/or minor procedures. I may discontinue this relationship at any time.

_____By initialing this line, I acknowledge that I have been provided with a Telehealth Informed Consent Informational Sheet and that I consent to the provision of some services to be provided by means of telehealth. I may withdraw my consent at any time by discontinuing the use of telehealth services without affecting my right to future care or treatment.

PART II DISCLOSURE OF INFORMATION CONSENT (treatment, payment or healthcare operations purposes only)

I consent to the use and disclosure of my health information; including medical, dental, HIV/AIDS, STD, TB, substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and health care operations. Additionally, I consent to my health information being shared in the Health Information Exchange (HIE), allowing access by participating doctors' offices, hospitals, care coordinators, labs, radiology centers, and other health care providers through secure, electronic means. If you choose not to share your information in the HIE, you may opt out by requesting and signing an HIE Opt-Out form.

PART III MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST (Only applies to Medicare Clients)

As Client/Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release my health information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the above-named agency and authorize it to submit a claim to Medicare for payment.

PART IV ASSIGNMENT OF BENEFITS (Only applies to Third Party Payers)

As Client /Representative signed below, I assign to the above-named agency all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personally responsible for charges not covered by this assignment.

PART V COLLECTION, USE OR RELEASE OF SOCIAL SECURITY NUMBER

(This notice is provided pursuant to Section 119.071(5)(a), Florida Statutes.)

For health care programs, the Florida Department of Health may collect your social security number for identification and billing purposes, as authorized by subsections 119.071(5)(a)2.a. and 119.071(5)(a)6., Florida Statutes. By signing below, I consent to the collection, use or disclosure of my social security number for identification and billing purposes only. It will not be used for any other purpose. I understand that the collection of social security numbers by the Florida Department of Health is imperative for the performance of duties and responsibilities as prescribed by law.

<u>PART VI</u> MY SIGNATURE BELOW VERIFIES THE ABOVE INFORMATION AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS

Client/Representative Signature	Self or Representative's Relationship to Client	Date
Witness (optional)	Date	
PART VII WITHDRAWAL OF CO	NSENT	
I,	WITHDRAW THIS CONSENT, effective	
Client/Representative Signature	Date	
DH 3204-SSG-02/2022		