

**PATIENT ELIGIBILITY SCREENING RECORD**  
**Idaho Vaccines for Children Program**

Date \_\_\_\_\_

Child \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last First MI

Parent/Guardian/  
Individual of Record \_\_\_\_\_ Provider \_\_\_\_\_

1. *This child qualifies for vaccination through the Vaccines for Children Program because he/she (check only one box):*

- (a) is enrolled in Medicaid  or
- (b) does not have Health Insurance  or
- (c) is American Indian or Alaskan Native  or
- (d) has health insurance for which  or  
vaccines are not a covered benefit

(Please check with your insurer to see if childhood immunizations are covered under your plan.)

2. *The child has Private Insurance that has a covered benefit for vaccines*

3. I will be responsible for balance owing on any vaccines and administration of vaccines that the insurance does not cover.

This record may be completed by the parent, guardian, or by the health care provider. It is necessary for the health care provider to retain this or a similar record for each child receiving vaccine.

\_\_\_\_\_  
Signature  
MCP-316

\_\_\_\_\_  
Date