Ohio - Vaccines for Children Program
VACCINE ELIGIBILITY FORM - for Private Practices

ODH Provider Number: ____ ____ ____ ____ ____

Accountability Period

From: _____ /_____ /_____

To: _____ /_____ /_____

PATIENT ELIGIBILITY STATUS
(Check ONE BOX for each child at FIRST VISIT ONLY!)

VACCINE DOSES ADMINISTERED
You may use check marks for each dose administered.
If you prefer to record lot numbers, a larger version of this form is available upon request.

Name	Date of Birth	Date of Service (mo / day)	Check when 1st dose of VFC vaccine is given during calendar year	Age is under 1 Year			Age is 1 to 6 Years			Age is 7 to 18 Yrs			DTaP or Ped DT *	DTaP + Hib + IPV (Pentacel)	DTaP + Hep B + IPV (Pediarix)	DTaP + IPV (Kinrix)	Hep A	Hep B	HIB	Human Papillomavirus (HPV)	IPV	MMR	Meningococcal (MCV4)	Pneumococcal PCV (or PPV *)	Rotavirus	Tdap or Td	VAR
				MEDICAID & MED. HMO'S	NO INSURANCE (Self pay)	NATIVE AMER. or ALASKAN	MEDICAID & MED. HMO'S	NO INSURANCE (Self pay)	NATIVE AMER. or ALASKAN	MEDICAID & MED. HMO'S	NO INSURANCE (Self pay)	NATIVE AMER. or ALASKAN															
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TOTAL *FIRST* VFC VISITS: (must equal sum of age totals)																											

Provider's Signature: **Date:**

TOTAL DOSES GIVEN AT *ALL* VFC VISITS - Use these numbers to calculate projected 3 - month usage when ordering vaccine

*Note -Pediatric DT and pneumococcal polysaccharide are provided ONLY upon written request by the physician, specifying patient's name and risk condition or contraindication.