Grace Health

Patient Eligibility Screening Record
Vaccines for Children Program

Child _____ Date _____
Last Name First Name MI

Date of Birth _____

Parent/Guardian _____
Last Name First Name MI

This child qualifies for vaccination through the VFC program because he/she:

[check only one box]

- ❑ is enrolled in Medicaid
- ❑ does not have health insurance
- ❑ is American Indian or Alaskan Native
- ❑ has health insurance that does not pay for vaccines

This child does not qualify for vaccination through the VFC program because he/she:

- ❑ has health insurance that pays for vaccines