

**Macomb County Health Department
Vaccine Eligibility Screening Form**

Name _____ Birthdate _____ Client ID Number _____

Please indicate which of the following applies to the child or person to be vaccinated today:

_____ Enrolled in Medicaid

_____ Today, has health insurance that **does not** provide any coverage for cost of immunizations.

_____ Does not have medical insurance

_____ Today, has health insurance** (other than Medicaid) that covers **all or part** of the cost of immunizations

_____ Is an American Indian or Alaskan Native

_____ **If fully insured and child under 19 years—My deductible or co-pay is preventing me from affording these vaccines at my doctor's office. (Menactra, Varicella or Tdap)

Signature of person to be vaccinated or person
authorized to make request

Date