



# Eligibility Screening Record

This record must be completed by the child's parent, guardian, or health care provider for children who receive immunizations through the Utah VFC Program.

Today's Date \_\_\_\_\_  
 Month Day Year

Child's Name \_\_\_\_\_  
 Last Name First Name Middle Initial

Date of Birth \_\_\_\_\_  
 Month Day Year

Parent or Guardian's Name \_\_\_\_\_  
 Last Name First Name Middle Initial

Health Care Provider \_\_\_\_\_

*To be completed by health care provider*

DATE SCREENED	VFC ELIGIBILITY* (Check only one category)					<b>NOT ELIGIBLE</b>
	ENROLLED IN MEDICAID	HAS NO HEALTH INSURANCE	AMERICAN INDIAN OR ALASKAN NATIVE	UNDER-INSURED	CHIP	INSURANCE COVERS VACCINATIONS**

\*This record must be kept with the child's medical record. It may be used for all subsequent visits and updated as the child's eligibility status changes. Parents or guardians must be asked about eligibility status at each visit. Verification of a child's eligibility status is NOT required.

\*\*Children with insurance, that has coverage for immunizations, are not eligible to receive VFC vaccines.



# El Registro de la Selección de la Elegibilidad

Este registro debe ser completada por el padre del niño, por el guardián, o por el doctor para los niños quién reciben las vacunas por El Program de Vacunas para los Niños del Estado de Utah.

La Fecha de Hoy \_\_\_\_\_  
Mes                      Dia                      Año

Nombre del Niño \_\_\_\_\_  
Apellido                      Nombre                      Inicial del Segundo Nombre

La Fecha del Nacimiento \_\_\_\_\_  
Mes                      Dia                      Año

Nombre del Padre o Guardián \_\_\_\_\_  
Apellido                      Nombre                      Inicial del Segundo Nombre

Nombre del Doctor \_\_\_\_\_

*Esta Sección debe ser completada por el doctor.*

DATE SCREENED	VFC ELIGIBILITY* (Check only one category)					<b>NOT ELIGIBLE</b>
	ENROLLED IN MEDICAID	HAS NO HEALTH INSURANCE	AMERICAN INDIAN OR ALASKAN NATIVE	UNDER-INSURED	CHIP	INSURANCE COVERS VACCINATIONS**

\*This record must be kept with the child's medical record. It may be used for all subsequent visits and updated as the child's eligibility status changes. Parents or guardians must be asked about eligibility status at each visit. Verification of a child's eligibility status is NOT required.

\*\*Children with insurance, that has coverage for immunizations, are not eligible to receive VFC vaccines.



# Vaccine Order Form

VFC PIN
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Fax order to (801) 538-9322

Date Submitted	Clinic Name	Phone with Area Code
Delivery Address (no PO Boxes)		<input type="checkbox"/> Check if new address
Person Completing Order (Print)	VFC Contact Person (Print)	<input type="checkbox"/> Check if new VFC Contact

All sections must be completed for your order to be processed. Orders submitted without complete VFC inventories will not be accepted.

VACCINE	ALL VFC DOSES IN INVENTORY	BRAND NAME (MANUFACTURER)	DOSES ORDERED	PACKAGING	VFC PROGRAM USE ONLY		
					Doses Filled	Doses Back Ordered	VacMan Entry Date
<b>VACCINES STORED IN THE REFRIGERATOR 35° - 46° F (2° - 8° C)</b>							
DT (<7 yrs)		Per State Contract		Single dose vials - 10 per box			
DTaP		<input type="checkbox"/> DAPTACEL (Sanofi)		Single dose vials - 10 per box			
		<input type="checkbox"/> Infanrix (GSK)		<input type="checkbox"/> Single dose vials - 10 per box <input type="checkbox"/> Single dose syringes - 5 per box			
		<input type="checkbox"/> Tripedia (Sanofi)		Single dose vials - 10 per box			
DTaP-Hep B-IPV		PEDIARIX (GSK)		<input type="checkbox"/> Single dose vials - 10 per box <input type="checkbox"/> Single dose syringes - 5 per box			
DTaP-HIB-IPV		Pentacel (Sanofi)		Single dose vials - 5 per box			
DTaP-IPV		KINRIX (GSK) - 4-6 yr booster only		<input type="checkbox"/> Single dose vials - 10 per box <input type="checkbox"/> Single dose syringes - 5 per box			
DTaP-HIB		TriHIBit (Sanofi) - 4 <sup>th</sup> dose only		Single dose vials - 5 per box			
IPV		IPOL (Sanofi)		<input type="checkbox"/> 10 dose vial - 1 per box <input type="checkbox"/> Single dose syringes - 10 per box			
Hep A		<input type="checkbox"/> Havrix (GSK)		<input type="checkbox"/> Single dose vials - 10 per box <input type="checkbox"/> Single dose syringes - 5 per box			
		<input type="checkbox"/> VAQTA (Merck)		Single dose vials - 10 per box			
Hep B (Preservative Free)		<input type="checkbox"/> ENGERIX-B (GSK)		<input type="checkbox"/> Single dose vials - 10 per box <input type="checkbox"/> Single dose syringes - 5 per box			
		<input type="checkbox"/> RECOMBIVAX HB (Merck)		Single dose vials - 10 per box			
Hep B-HIB		COMVAX (Merck)		Single dose vials - 10 per box			
HIB		<input type="checkbox"/> ActHIB (Sanofi)		Single dose vials - 5 per box			
		<input type="checkbox"/> PedvaxHIB (Merck)		Single dose vials - 10 per box			
HPV		GARDASIL (Merck)		Single dose vials - 10 per box			
Meningococcal		Menactra (Sanofi)		Single dose vials - 5 per box			
MMR		MMR II (Merck)		Single dose vials - 10 per box			
Pneumococcal		Prevnar (Wyeth)		Single dose syringes - 10 per box			
Rotavirus		<input type="checkbox"/> ROTARIX (GSK)		Single dose applicators - 10 per box			
		<input type="checkbox"/> RotaTeq (Merck)		Single dose tubes - 10 per box			
Td (≥7 yrs) (Preservative Free)		DECAVAC (Sanofi)		<input type="checkbox"/> Single dose vials - 10 per box <input type="checkbox"/> Single dose syringes - 10 per box			
Tdap		<input type="checkbox"/> ADACEL (Sanofi) 11-18 yrs*		<input type="checkbox"/> Single dose vials - 10 per box <input type="checkbox"/> Single dose syringes - 5 per box			
		<input type="checkbox"/> BOOSTRIX (GSK) 10-18 yrs		<input type="checkbox"/> Single dose vials - 10 per box <input type="checkbox"/> Single dose syringes - 5 per box			
<b>VACCINES STORED IN THE FREEZER 5° F or below (-15° C or below)</b>							
Varicella		VARIVAX (Merck)		Single dose vials - 10 per box			

**\*\*Note: If the vaccine brand selected is not available orders will be filled with a vaccine brand in inventory.**

## Instruction for Completing the VFC Vaccine Order Form

To ensure that your vaccine order is processed as quickly as possible, the VFC Vaccine Order Form **must** be fully completed. Fill in all blank sections of the form. Orders submitted on outdated forms may delay the processing of your vaccine order.

Please place orders according to your designated ordering schedule (monthly, every other month, quarterly). If you are not familiar with your clinic's ordering schedule, please contact your regional representative at (801) 538-9450.

### Instructions:

- 1. Enter clinic's VFC PIN -- Use on all orders**  
Provider Identification Number assigned to your clinic by the Utah VFC Program.
- 2. Enter Date Submitted**  
Date clinic submits the order to the Utah VFC Program.
- 3. Enter Clinic Name**  
Name of healthcare provider enrolled as a VFC provider. Please notify the Utah VFC Program if clinic name changes.
- 4. Phone Number with Area Code**  
Number to contact you if there is a question regarding your order.
- 5. Specify the delivery address**  
To ensure vaccine is delivered to the correct address please provide us with the current vaccine delivery address. Check the box if this is a new address.
- 6. Enter Name of Person Completing Order**  
Print clearly the person completing the order form so we may contact you if there is a question regarding your order.
- 7. Enter Name of VFC Contact Person**  
Print clearly the person responsible for the VFC Program in your clinic. Check the box if this is a new VFC Contact.
- 8. List current inventory of all VFC vaccines**  
List the **total** amount of VFC vaccine on-hand in your refrigerator/freezer for all vaccines.  
Orders submitted without VFC inventories **will not** be accepted.  
Do not report inventory of privately purchased vaccines.
- 9. Select product choice and indicate the number of vaccine doses requested**  
If vaccine brand selected is not available, orders will be filled with a vaccine brand in inventory.  
The number of doses requested should be in multiples of 5 or 10 depending on the available packaging for that vaccine.
- 10. Indicate packaging preference for requested product.**  
When indicated, check your choice of product packaging. If you do not specify a packaging preference or the packaging is not available, the Utah VFC Program will send vaccine that is currently in inventory.

### ***Always keep a copy for your records!***

Fax the completed vaccine order form to the Utah VFC Program at (801) 538-9322

#### **Helpful Hints for Ordering Vaccine**

**Vaccine deliveries are determined by the day of the week the order is received** by the Utah VFC Program and the delivery days/times indicated on your *Provider Profile and Enrollment* form. Notify the Utah VFC Program if your delivery times/clinic hours change.

- Vaccines are shipped from McKesson Speciality Distribution in Sacramento, CA on Monday, Tuesday, or Wednesday. Vaccines are not typically shipped from the depot on Thursday or Friday to avoid weekend delivery and vaccine spoilage.
- Varicella is shipped separately from other vaccines. These vaccines are shipped directly from Merck.

For questions regarding vaccine orders, call the Utah VFC Program at (801) 538-9450.



# Provider Vaccine Inventory

VFC PIN
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## All State Supplied Vaccines

Date Submitted	Clinic Name	Phone with Area Code
Person Completing Report		Nursing Director Signature

Vaccine Type	Manufacturer	Lot Number	Expiration Date	Number of Doses	Grand Total
DT					
DTaP					
DTaP-Hep B-IPV					
DTaP-HIB-IPV					
DTaP-HIB					
DTaP-IPV					
IPV					
Hep A Pediatric					
Hep B Pediatric					
Hep B-HIB					

Date Submitted	VFC PIN	Clinic Name			
HIB					
HPV					
Meningococcal					
MMR					
MMRV					
Pneumococcal					
Rotavirus					
Td (≥7 yrs)					
Tdap					
Varicella					

**Instructions**

1. For each vaccine listed, allow one row for each lot number and fill in all information requested.
2. For each vaccine type, add the total number of doses together. List the resulting sum in the Grand Total column.
3. Make a photocopy for your records and submit form with your vaccine order by FAX to (801) 538-9322 or mail to the Utah VFC Program.



## Quarterly Doses Administered Report

For Private / Public Provider use

VFC PIN
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2. Clinic Name	Phone #
Name of Person Submitting Form	Quarter / Year
3. I certify under penalty of law that the below information is true.	Signature
	Date

### Instructions for Completing the Quarterly Doses Administered Report

Complete and submit this form to the Utah VFC Program within 15 days following the end of each quarter.

<b>1<sup>st</sup> Quarter:</b>	<i>January, February, March</i>	Due <b>April 15<sup>th</sup></b>
<b>2<sup>nd</sup> Quarter:</b>	<i>April, May, June</i>	Due <b>July 15<sup>th</sup></b>
<b>3<sup>rd</sup> Quarter:</b>	<i>July, August, September</i>	Due <b>October 15<sup>th</sup></b>
<b>4<sup>th</sup> Quarter:</b>	<i>October, November, December</i>	Due <b>January 15<sup>th</sup></b>

1. Enter VFC Pin. (Verify if unsure of correct number.)
2. Print the clinic name, phone number, quarter and year of this report, and name of the person completing this form.
3. Read the attestation statement, sign and date. (Forms will not be accepted without signature.)
4. On the Total Number of Patients Vaccinated table, enter the number of VFC eligible children who received vaccines, by age and eligibility categories. **Total** each row and column.
5. Page two (reverse side), print clinic name and VFC Pin in top boxes. (When faxed, pages are separated.)
6. On the Total Number of VFC Doses Administered table, enter the number of doses administered to VFC eligible children, by age and vaccine type. **Total** each row and column.
7. On the Total Number of Underinsured Doses Administered table, enter the number of doses administered to underinsured children, by age and vaccine type. **Total** each row and column.
8. On the Total Number of CHIP Doses Administered table, enter the number of doses administered to CHIP enrolled children, by age and vaccine type. **Total** each row and column.

**Use of Doses Administered Tally Sheet is Optional.  
Please do NOT return Tally Sheets.**

Mail or fax the Quarterly Doses Administered Report to:  
 Utah Department of Health  
 Immunization Program  
 PO Box 142001  
 Salt Lake City, UT 84114-2001  
 (801) 538-9450  
**FAX: (801) 538-9440**

4. Total Number of <b>Patients Vaccinated</b>						
Age	Vaccines for Children (VFC)			State Supplied		TOTAL
	Am. Indian/ Alaskan Nat.	Medicaid	Non-insured	Underinsured	CHIP	
<1						
1-6						
7-18						
>18						
<b>Total</b>						





### **Instructions for Completing the *Optional VFC* Tally Sheet**

Each child receiving VFC vaccine in the clinic should be accounted for on this form. This tally sheet compiles the information necessary to complete the *Quarterly Doses Administered Report*.

- Print the clinic name and the quarter / year of this information.
- Place a check mark in the appropriate age and eligibility status column. (One line per child.)
- Place a check mark in the column for each vaccine administered to the child during the visit.
- Total all columns (Eligibility Status and Vaccines).
- Transfer the Totals to the Quarterly Doses Administered Report.

**Tally Sheets are for provider's use only.**

**Do NOT return to the Utah VFC Program.**



### **Instructions for Completing the *Optional* Under-insured Tally Sheet**

Each child receiving State Supplied vaccine in the clinic should be accounted for on this form. This tally sheet compiles the information necessary to complete the *Quarterly Doses Administered Report*.

- Print the clinic name and the quarter / year of this information.
- Place a check mark in the appropriate age and eligibility status column. (One line per child.)
- Place a check mark in the column for each vaccine administered to the child during the visit.
- Total all columns (Eligibility Status and Vaccines).
- Transfer the Totals to the Quarterly Doses Administered Report.

**Tally Sheets are for provider's use only.**

**Do NOT return to the Utah VFC Program.**



### **Instructions for Completing the *Optional* CHIP Tally Sheet**

Each child receiving State Supplied CHIP vaccine in the clinic should be accounted for on this form. This tally sheet compiles the information necessary to complete the *Quarterly Doses Administered Report*.

- Print the clinic name and the quarter / year of this information.
- Place a check mark in the appropriate age and eligibility status column. (One line per child.)
- Place a check mark in the column for each vaccine administered to the child during the visit.
- Total all columns (Eligibility Status and Vaccines).
- Transfer the Totals to the Quarterly Doses Administered Report.

**Tally Sheets are for provider's use only.**

**Do NOT return to the Utah VFC Program.**



## Instruction for Completing the VFC Vaccine Return and Transfer Form

Notify the Utah VFC Program immediately of any vaccine loss. You must have **prior approval** before returning or transferring any VFC vaccines.

### Instructions:

**1. Enter clinic's VFC PIN**

Provider Identification Number assigned to your clinic by the Utah VFC Program.

**2. Enter Date Submitted**

Date clinic submits the return request to the Utah VFC Program.

**3. Phone Number with Area Code**

Number to contact you if there is a question regarding the vaccine.

**4. Enter Clinic Name**

Name of healthcare provider enrolled as a VFC provider. Please notify the Utah VFC Program if clinic name changes.

**5. Enter Name of VFC Contact Person**

Print clearly the person responsible for the VFC Program in your clinic.

**6. List all VFC vaccines returned or transferred**

Include all the information about each vaccine being returned or transferred. The required information can be found on the box or vial of vaccine.

**7. List reason you are returning vaccine**

A list of reason codes can be found at the bottom of the table. Please put the appropriate number in the Reason Returned column on the right hand side of the form. A reason must be listed for each returned vaccine.

**8. Complete Incident Report and Plan of Action**

An incident report of the events that led to the non-viable vaccine should be listed in the box provided.

A plan of action to keep the incident from reoccurring should be listed in the box provided.

The incident report / plan of action may be submitted on a separate sheet of paper if the box provided is not sufficient space.

**9. Returning vaccine to McKesson Specialty Distribution**

Notify the Utah VFC Program that your clinic has expired or spoiled vaccine **prior to returning** to McKesson Distribution.

Fax the completed Vaccine Return and Transfer Form to the Utah VFC Program at (801) 538-9440.

The Utah VFC Program will notify McKesson the clinic is returning vaccine.

Package expired or spoiled vaccine in a shipping container from McKesson, include a copy of the completed form.

Ship vaccine to McKesson using the return postage slip provided on the shipping container.

**\*\*Returning vaccine due to a spoilage incident, fax additional documents to the Utah VFC Program\*\***

1. The completed Emergency Response Worksheet.
2. Complete temperature logs for the last two weeks.

**10. If transferring VIABLE vaccine to another clinic**

Notify the Utah VFC Program for **prior approval** and assistance before transferring any VFC vaccines.

Fax the completed the Vaccine Return and Transfer Form to the Utah VFC Program.

***Always keep a copy for your records!***

- ♦ At the first sign of a refrigerator failure or other incident that may interrupt maintaining the "cold chain," refer to your Emergency Vaccine Handling Plan and complete the Emergency Response Worksheet. Refrigerate the vaccines appropriately and don't
- ♦ Return only those vaccines received from the Utah Immunization Program/Utah VFC Program. Never return viable vaccines to the Utah VFC Program; instead transfer them to another VFC Provider. Contact the Utah VFC Program for assistance.
- ♦ Use vaccines through the printed expiration date. If an expiration date is month and year only, it is viable until the last day of
- ♦ Contact the Utah VFC Program at (801) 538-9450 for additional information or training on vaccine storage and handling.