

# Londonderry Pediatrics Tuberculosis Risk Assessment

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Today's Date \_\_\_\_\_

Please read the questions and circle the answer that applies to your child.

1) Are there any household members who have recently been treated for TB?

YES                  NO

2) Are you aware of any cases of TB in your neighborhood?

YES                  NO

3) Does your child have a problem with his or her immune system?

YES                  NO

4) Has your child ever lived in a foreign country?

YES                  NO

5) If you answered YES to question #4, has your child ever received BCG vaccine for TB?

YES                  NO

\_\_\_\_\_  
Name of parent/guardian

\_\_\_\_\_  
Relationship

Please bring the completed form to your child's well visit. Thank you.

Londonderry Pediatrics, PA  
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Londonderry, NH 03053

## VFC Eligibility

Children through 18 years of age who meet at least one of the following criteria are considered federally vaccine-eligible and therefore eligible to participate in the VFC program:

- **Medicaid eligible:** A child who is eligible for the Medicaid program. (For the purposes of the VFC program the terms Medicaid-eligible and Medicaid-enrolled are equivalent and refer to children who have health insurance covered by a state Medicaid program)
- **Uninsured:** A child who has no health insurance coverage
- **Indian (American Indian or Alaska Native):** As defined by the Indian Health Care Improvement Act (25 U.S.C. 1603)
- **Underinsured:** Children who have commercial (private) health insurance but the coverage does not include vaccines, children whose insurance covers only selected vaccines (VFC - eligible for non-covered vaccines only), or children whose insurance caps vaccine coverage at a certain amount--once that coverage amount is reached, these children are categorized as underinsured. **Underinsured children are eligible to receive VFC vaccine only through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).**

Name:

\_\_\_\_\_

Last,	First,	MI	Birth date	Age
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Signature \_\_\_\_\_

Is enrolled in Medicaid	Yes	No	Date
Is Native American	Yes	No	Date
Doesn't have insurance	Yes	No	Date
Is Underinsured (Insurance does not cover the cost of vaccines)	Yes	No	Date