Parent and Patient Survey 8, 9, 10 years

Name:_____ DOB:_____

What grade are you in?

What do you like most about school?

What were your grades on your last report card or progress report?

Do you have friends at school?

What kinds of activities are you involved in or after school?

Have you ever done something you think you shouldn't have or gotten in trouble?

What are you best at?

What are you really proud of?

Do you have close friends?

What do you like to do with your friends?

Does anyone in your family have	Diabetes	N	Y	Who?
	Skin cancer	N	Y	Who?
	High Cholesterol	N	Y	Who?
	High Blood Pressure	N	Y	Who?

Do you have any worries about your body or your health?

What type of foods do you most enjoy?

Do you exercise regularly, as in playing a sport or dancing or gymnastics?

Do you take a medicine every day?

Do you brush your teeth twice a day?

Does a dentist clean your teeth twice a year?

What are your thoughts about smoking?

Do you and your friends talk about drugs and alcohol?

During the past month, have you often been bothered by feeling down or hopeless?

During the past month, have you often been bothered by little interest or pleasure in doing things?

Signature:_____

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
25 Buttrick Road, Bldg. E
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

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