Child and Teen Immunization Questionnaire

Last Name _____ First Name _____ Middle Initial_____

Date of Birth ____/____/____ Age_____ Male/Female Race_____

Street Address_____ City _____ State_____ Zip Code_____

Phone Number _____ Social Security #_____

☐ **Check this box if you wish to receive text alerts for upcoming appointments**

Parent/Guardian's Name _____

Does the child have health insurance? Yes or No Name of Medical Insurance _____

ID #_____ MMIS #_____

1. **Is the child sick today (fever, cough)? Yes No**
2. **Has the child had serious reaction to a vaccine in the past? Yes No**
   a. **If yes, which vaccine & what reaction: _____**
3. **Does the child have an allergies to medication, food, or Latex? Yes No**
4. **If you child is baby (less than 1 years of age), has he or she been diagnosed with Intussusception? Yes No**
5. **Has the child, a sibling, or parent had a seizure? Yes No**
6. **Does the child have cancer, HIV/AIDS, or any other immune system problem? Yes No**
7. **Does your child take any medication daily? Yes No**
   a. **If yes, what medications: _____**
8. **In the past year has the child received a transfusion or blood or blood products? Yes No**
9. **Has the child received any vaccines in the last 4 weeks? Yes No**
10. **Is the child/teen pregnant? Yes No**

I have received a copy(s) of the Vaccine Information Statement(s) for each of the vaccine(s) that my child will receive today and I understand the risk and benefits of the vaccine(s). I grant permission for the Massillon City Health Department's Nursing Staff to administer the immunization(s). I authorize my child's Immunization Record to be entered into the Ohio Immunization Registry and to be released as needed to medical providers, schools, and health departments.

By signing this form, I acknowledge that I have received or read a copy of the Notice of Privacy Practices.

Parent/Guardian's Signature _____ Date _____

Staff use Reviewed by: _____ Date _____

DCL: ADM: Next scheduled appointment _____