Massillon
City of Champions
Health Department

CHILD AND TEEN SCREENING QUESTIONNAIRE

Child's Last Name _____ First Name _____ M.I. ____ Physician _____

Date of Birth _____ Age _____ Male / Female Race _____ Birth Hospital _____

Address _____ City _____ State _____ Zip Code _____

Phone _____ SS# _____

Print Mother's/Guardian's Name _____ Print Father's/Guardian's Name _____

Does the child have insurance? Yes No Primary Medical Insurance _____

Name of Primary Medical Insurance _____

ID# _____ MMIS# _____

Does insurance pay for some immunizations?	Yes	No	Don't Know
Does it pay for all immunizations?	Yes	No	Don't Know
Covers immunizations, but has a cap	Yes	No	Don't Know

Name of Secondary Medical Insurance _____

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1.	Is the child sick today?	Yes	No
2.	Has the child had a serious reaction to a vaccine in the past?	Yes	No
3.	Does the child have allergies to medications, food, a vaccine component, or Latex?	Yes	No
4.	If your child is a baby, have you ever been told he or she has had Intussusception?	Yes	No
5.	Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?		
6.	Does the child have cancer, leukemia, HIV / AIDS, or any other immune system problem?	Yes	No
7.	In the past three months has the child taken medication such as prednisone, other steroids, or anti-cancer drugs; drugs for the treatment of rheumatoid arthritis, Chron's Disease, or psoriasis; or had radiation treatments?	Yes	No
8.	In the past year has the child received a transfusion of blood or blood products, or been given immune gamma globulin?	Yes	No
9.	Has the child received vaccinations in the last 4 weeks?	Yes	No
10.	Is the child or teen pregnant or is there a chance she could become pregnant during the next 4 weeks?	Yes	No

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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 also acknowledge that I have received or read a copy of the Notice of Privacy Practices.

Parent/Guardian's Signature _____ **Date** _____

Reviewed by _____ **Date** _____

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STAFF ONLY DCL: ADM: Next scheduled appointment _____