Today's Date: _____

Public Health
Prevent. Promote. Protect.
Canton City Public Health

Immunization Child Health History

Child Last Name: _____ Date of Birth: _____ Age: _____

Child First Name: _____ Middle: _____ Sex: Male Female

Address: _____ Apt#: _____

City: _____ State: _____ Zip Code: _____ County: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Race: ☐ Am. Indian/Alaskan Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐

Name of Parent/Guardian: _____ Guardian Paperwork? Yes _____ No _____

Parent/Guardian Date of Birth: _____ Relationship to Patient: _____

Name of Insurance: _____

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1. Has your child been sick in the last 24 hours? Yes _____ No _____
2. Does your child have allergies to medications, food, a vaccine component, or latex? Yes _____ No _____
   If yes, please detail _____
3. Has your child had a serious reaction to a vaccine in the past? Yes _____ No _____
4. In the past year, has your child received blood or blood products, or been given immune (Gamma) globulin or an antiviral drug? Yes _____ No _____
5. Does your child have a long-term health problem such as lung, heart, kidney, neurologic or metabolic disease (i.e. diabetes), asthma, blood disorder, no spleen, complement component deficiency, cochlear implant, bladder exstrophy, or spinal fluid leak/spina bifida? Is he/she on long-term aspirin therapy? Yes _____ No _____
6. Has your child ever had chickenpox disease? Yes _____ No _____
7. If your child is a baby, have you ever been told he/she has had intussusception? Yes _____ No _____
8. Has your child had a seizure or other brain or other nervous system problems? Does your child have a sibling or parent who has had a seizure? Yes _____ No _____
9. Does your child have cancer, leukemia, HIV/AIDS, or any other immune system problem? Yes _____ No _____
10. Does your child have a sibling or parent with an immune system problem? Yes _____ No _____
11. In the past 3 months, has your child taken medications that affect the immune system such as Prednisone, other steroids, or anticancer drugs; drugs for treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments? Yes _____ No _____
12. Has your child received vaccinations in the past 4 weeks? Yes _____ No _____
13. Is your child/teen pregnant or is there a chance of becoming pregnant within the next month? Yes _____ No _____
    First day of last period: _____ (mm/dd/yyyy) N/A _____

I have received a copy of the Vaccine Information Statement(s) regarding the diseases and vaccines. I grant permission for vaccines that my child is due to receive be given to him/her today. I understand that MMR, Chickenpox and/or HPV vaccine should NOT be given to pregnant females. I also understand that the person receiving these vaccines should not become pregnant for one month. I grant permission for this record to be released to medical providers, health departments and schools to transmit the immunization history. By signing this form, I also acknowledge that I have received a copy of the Notice of Privacy Practices.

Signature: _____ Date: _____

Form Reviewed by: _____ Date: _____

Child First Name: _____ Last Name: _____ Age: _____

COVID-19
Health History for 6 Months through 11 Years of Age

1. Is your child feeling sick today? Yes _____ No _____

2. Has your child ever had a severe allergic reaction (e.g. anaphylaxis) that needed treated with epinephrine or EpiPen® or a trip to the hospital after receiving: a COVID-19 vaccine, a component of a COVID-19 vaccine (i.e. Polyethylene glycol, Polysorbate), or any other vaccine or injectable medication? Yes _____ No _____

3. Has your child had a health problem with lung, heart, kidney or metabolic disease (i.e. diabetes), asthma, a blood clotting disorder, taking blood thinners, or been diagnosed with myocarditis, pericarditis or Guillain-Barré syndrome? Yes _____ No _____

4. Does your child have a weakened immune system caused by something such as cancer, leukemia, HIV/AIDS, or any other immune system problem or has your child taken medications in the past 3 months that affect the immune system such as Prednisone, other steroids, or anticancer drugs; drugs for treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments? Yes _____ No _____

5. Has your child received a hematopoietic cell transplant (HCT) or chimeric antigen receptor CAR-T-cell therapies since receiving a COVID-19 vaccine? Yes _____ No _____

6. Has your child had a positive test for COVID-19 or has a doctor told you that your child has had COVID-19 or Multisystem inflammatory Syndrome in children (MIS-C) related to COVID-19? Yes _____ No _____

   a. If yes, when _____

7. Has your child received passive antibody therapy (monoclonal or convalescent plasma) for COVID-19 in the last 3 months? Yes _____ No _____

COVID-19 Immunization Consent

I have received and reviewed the COVID-19 Vaccination Consent Disclosure Statement and the COVID-19 Emergency Use Authorization Fact Sheet. I understand there is a risk of slight to severe reaction with any vaccination. I also understand that this is a less risk than the risk to an unvaccinated person who could acquire this disease. By signing this form, I also acknowledge that I have received a copy of Canton City Public Health's Notice of Privacy Practices. I also grant permission for this record to be released to medical providers, health departments, and to transmit to the immunization registry.

Patient/Guardian Signature: _____ Date: _____

Printed Name: _____

Form Reviewed by: _____ Date: _____