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: _____

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 _____