CANTON CITY HEALTH DEPARTMENT CHILD TRAVEL CLINIC

Child's Last Name _____First_____Middle_____

Address_____City_____ State____ Zip Code_____

County _____ Phone Number_____ Sex (circle) M F

Birth Date_____ Age _____ Height_____ Weight _____ Race: Black ☐ White ☐ Other ☐

Child's Doctor _____ Country Traveling To/How long_____

Parent/Guardian Name _____

Insurance Status:

___ I have **Care Source** Medicaid #_____ ____ I have private insurance through my work - does it currently cover shots?_____

___ I have **Buckeye** Medicaid #_____

___ I have **Medicaid** # _____ ____ I do not have any insurance

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1. Has your child been sick in the last two weeks? Yes____No____

2. Does your child have any serious or chronic illness? If yes, what_____ Yes____No____

3. Is your child taking any medicine at this time? If yes, what_____ Yes____No____

4. Has your child received blood, blood products, or Gamma Globulin in the past six months? Yes____No____

5. Has your child ever had:
   - a severe reaction to shots? Yes____No____
   - a severe reaction to any medication? Yes____No____
   - convulsions or seizures? Yes____No____
   - Allergies? Specify_____ Yes____No____

6. Does your child have allergies to: (Circle your answer/or answers) Yes____No____
   a. chicken b. eggs c. bakers yeast d. gelatin

7. Has your child ever had chickenpox disease? Yes____ No____
   Has your child ever received the chickenpox vaccine? Yes____ No____

8. Has your child previously received immunizations at the Canton City Health Dept? Yes____No____
   If no, where were shots given?_____

9. Has your child received vaccines anywhere since the last visit here? Yes____No____

10. Has your child had a live vaccine in the past 28 days (MMR, Chickenpox, Flumist, Yellow Fever)? Yes____ No____

11. If your child is under 5 years old, is he/she enrolled in WIC? Yes____ No____

12. Are you the child's parent or legal guardian? Yes____No____

I have received a copy of the Vaccine Information Statement(s) regarding the diseases and vaccines and understand there is a risk of slight to sever reaction with any vaccination. I also understand that this is a less risk than the risk to an unvaccinated person who could acquire one of these diseases. By signing this form, I acknowledge that I have received a copy of our Notice of Privacy Practices. I also grant permission for this record to be released to medical providers, health departments and schools to transmit the immunization history.

Signature_____ Date_____

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Adolescent females <u>ONLY</u>

Date of last menstrual period: _____

I understand that certain vaccines should **<u>NOT</u>** be given to pregnant females. I also understand that the person getting such vaccines should avoid becoming pregnant for a four week period.

Signature of parent/guardian_____