HEALTH HISTORY

Child's Last Name ____________________________________First___________________Middle___________

Address____City__________________ State_________________

Zip Code__________County _______________ Sex (circle) M F

Birth Date________________ Age _____ Race _______________Phone Number __________________________

Child's Doctor ___________________________________ Birthing Hospital ___________________________

Parent/Guardian Name _____________________________

Insurance Status:

___ I have **Care Source #**___________________________________

___ I have **Buckeye** # ____________________________________

___ I have **Medicaid #**____________________________________

___ I have **Unison #**_______________________________________

____ I have private insurance through my work - does it currently cover shots? __________

____ I do not have any insurance

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1. Has your child been sick in the past two days? If yes, explain___________________________ Yes______No______
2. Does your child have a fever today? Yes______No______
3. Does your child have any serious or chronic illness? If yes, what________________________ Yes______No______
4. Is your child taking any medicine at this time? If yes, what_____________________________ Yes______No______
5. Has your child received blood, blood products, or Gamma Globulin in the past six months? Yes______No______
6. 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______
7. Has your child ever had chickenpox disease? Yes______No______
   Has your child ever received the chickenpox vaccine? Yes______No______
8. I understand that MMR, Varicella and/or Gardasil vaccine should **NOT** be given to pregnant females. I also understand that the person getting these vaccines should avoid becoming pregnant for a three-month period. Date of last menstrual period for person receiving any of the above vaccines:____
9. Has your child previously received immunizations at the Canton City Health Dept? Yes______No______
   If no, where were shots given?____
10. Has your child received vaccines anywhere since the last visit here? 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. I grant permission for vaccines that my child is due to receive be given to him/her today. 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______________________

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