

HEALTH HISTORY

Child's Last Name _____ First _____ Middle _____

Address _____ City _____ State _____

Zip Code _____ County _____ Sex (circle) M F Birth Date _____ Age _____ Race _____

Parent/Guardian Name _____ Phone Number _____

Child's Doctor _____ Birthing Hospital _____

Insurance Status:

____ I have **Medicaid** # _____ I have private insurance that covers the cost of shots **100%**

____ I have **Buckeye** # _____ I have private insurance that **does not** cover shots 100%

____ I have **CareSource** # _____ I do not have any insurance

____ I have **United Health Care** # _____

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1. Does your child have a fever today? Yes _____ No _____
 2. I would like **ALL** recommended shots to be given to my child today. (If **Yes**, Skip question 3) Yes _____ No _____
 3. I would like **ONLY** the following shots to be given to my child today (Please Circle Shots that you wish to be given):
DtaP HepB Hib Polio Prevnar Rotavirus HepA MMR Chickenpox Tdap Td Meningitis HPV
 4. Does your child have any serious or chronic illness? If **Yes**, list illness: _____ Yes _____ No _____
 5. Is your child taking any medicine at this time? If **Yes**, list medication: _____ Yes _____ No _____
 6. Has your child received blood, blood products, or Gamma Globulin in the past six months? Yes _____ No _____
 7. Has your child ever had:
Severe reaction to shots? Yes _____ No _____
Severe reaction to any medication? Yes _____ No _____
Convulsions or seizures? Yes _____ No _____
Allergies? Specify _____ Yes _____ No _____
 8. Has your child ever had chickenpox disease? Yes _____ No _____
Has your child ever received the chickenpox vaccine? Yes _____ No _____
 9. Does your child have menstrual periods? Yes _____ No _____
If **Yes**, what was the first day of the **last menstrual period**? Month _____ Day _____ Year _____
 10. I understand that MMR, Chickenpox and/or HPV vaccine should **NOT** be given to pregnant females. I also understand that the person getting these vaccines should not become pregnant for a three-month period. Yes _____ No _____
 11. Has your child previously received immunizations at the Canton City Health Dept? Yes _____ No _____
If **No**, where were shots given? _____
 12. Has your child received vaccines anywhere since their last visit to the Canton City Health Dept? Yes _____ No _____
If **Yes**, where were shots given? _____
 13. If your child is under 5 years old, is he/she enrolled in WIC? Yes _____ No _____
 14. 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 _____