Today's Date: _____

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: _____

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

Name of Insurance: _____

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1. Does your child have a fever today? Yes _____ No _____
2. Does your child have allergies to medications, food, a vaccine component, or latex? Yes _____ No _____
   If yes, please detail _____
3. Does your child take daily medication? Yes _____ No _____
   If yes, please detail _____
4. Has your child had a serious reaction to a vaccine in the past? Yes _____ No _____
5. In the past year, has your child received blood or blood products, or been given immune (Gamma) globulin or an antiviral drug? Yes _____ No _____
6. Has your child had a health problem with lung, heart, kidney or metabolic disease (i.e. diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy 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, a sibling, or a parent had a seizure? Has your child had brain or other nervous system problems? Yes _____ No _____
9. Does your child have cancer, leukemia, HIV/AIDS, or any other immune system problem? Yes _____ No _____
10. 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 _____
11. Has your child received vaccinations in the past 4 weeks? Yes _____ No _____
12. Has your child ever had chicken pox disease? Yes _____ No _____
13. If your child is 13 years or older, does your child smoke? Yes _____ No _____
14. 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 3-month period. First day of last period: _____ (mm/dd/year) N/A _____ Yes _____ No _____
15. If your child is under 5 years old, is he/she enrolled in WIC? 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_____

Form Reviewed by: _____ Date _____