

SCREENING QUESTIONNAIRE FOR CHILD AND TEEN IMMUNIZATIONS

Child's Last Name _____ First Name _____ M.I. _____ Physician _____

Date of Birth _____ Age _____ Male / Female _____ Race _____ Birth Hospital _____

Address _____

City _____ State _____ Zip Code _____ Phone _____

SS# _____

Print name of Parent / Guardian _____

Does the child have insurance? **Yes** **No**

Name of Primary Medical Insurance _____

ID# _____ Plan _____ MMIS# _____

Does insurance pay for some immunizations?	Yes	No	Don't Know
Does it pay for all immunizations?	Yes	No	Don't Know
Covers immunizations, but has a cap	Yes	No	Don't Know

Name of Secondary Medical Insurance _____

Is the child sick today?	Yes	No
Has the child had a serious reaction to a vaccine in the past?	Yes	No
Does the child have a serious chronic illness?	Yes	No
Does the child have allergies to medications, food, vaccines or Latex?	Yes	No
Has the child had a seizure, brain or other nervous system problems?	Yes	No
Has the child received blood, blood products, or Gamma Globulin in the past six months?	Yes	No
Is the child currently taking medication?	Yes	No
Is the child/teen pregnant or planning to become pregnant?	Yes	No
Has the child received vaccinations in the past 4 weeks?	Yes	No

I have received a copy(s) of the Vaccine Information Statement(s) for each of the vaccine(s) that my child will receive today and I understand the risk and benefits of the vaccine(s). I grant permission for the Massillon City Health Department's Nursing Staff to administer the immunization(s). I authorize my child's Immunization Record to be released as needed to medical providers, schools and health departments.

By signing this form, I also acknowledge that I have received or read a copy of the Notice of Privacy Practices.

Parent/Guardian's Signature _____ **Date** _____

Reviewed by _____ **Date** _____

STAFF ONLY **DCL:** **ADM:**

Next scheduled appointment _____