

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# _____

Parent / Guardian Name _____

Medical Insurance: _____ I have private insurance that:

- _____ pays for shots
- _____ covers some shots
- _____ covers shots but has a cap
- _____ does not pay for shots

- _____ Healthy Start/Medicaid
- _____ United Health Care
- _____ Buckeye
- _____ Caresource

_____ I have no insurance

Billing or MMIS # _____

- | | | |
|---|-----|----|
| 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 _____