Public Health
Prevent. Promote. Protect.
MORGAN COUNTY HEALTH DEPT.

Morgan County Health Department
4275 N SR376 NW
McConnelsville, OH 43756
Phone: 740-962-4572
Fax: 740-962-3271

Today's Date: _____

Immunization Child Health History

Child Name: _____ **Date of Birth:** _____

Age: _____ **Sex:** ☐ **Male** ☐ **Female**

Address: _____ **City:** _____ **State:** _____

Zip Code: _____ **County:** _____ **Home Phone:** _____ **Cell Phone:** _____

Race: ☐American 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**: _____

Email Address:_____

1. Does your child have a fever today? ☐Yes ☐No
2. Does your child have allergies to medications, food, a vaccine component, or latex?
   If yes, please detail _____ ☐Yes ☐No
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. Is the child/teen pregnant or is there a chance she could become pregnant during this month? ☐ N/A ☐Yes ☐No
15. If your child is under 5 years old, is he/she enrolled in WIC? ☐Yes ☐No

PLEASE CHECK ONLY ONE (1) BOX BELOW:

This child qualifies for vaccination through the VFC program because he/she:

☐Child is enrolled in Medicaid or,
☐ Does Not have Health Insurance or,
☐ Is American Indian or an Alaskan Native, or
☐ Has Health Insurance that does Not Pay for Vaccines

Did you bring your immunization record card with you? 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. **(check all that apply)**

Signature_____ Date_____

Form Reviewed by: _____ Date _____