Please complete this survey and have your child return it to his or her teacher by **(insert date).** ID Number:_____
All information will be kept strictly confidential. Your participation is completely voluntary; if you do not want to answer any or all questions you don't have to. (for office use only)
Parents/Guardians with more than one child in school should fill out a separate survey for each child

Survey for Parents/Guardians of Children

1. Name of person completing this form: _____
2. Relationship to child: □ Parent □ Other (please specify): _____

3. Child's Name: _____
   Child's Address: _____
   _____Zip code_____
   Parents' Telephone: (____)_____
4. Child's date of birth: ____/____/____
   Month Day Year
5. Child's age: _____ years
6. Sex of child: □ Male □ Female

7. Child's Race/Ethnicity: (Check one)
   □ African-American □ Asian/ Pacific Islander □ Native American/Alaskan □ Hispanic
   □ White (Caucasian) □ Other (please write): _____
8. **Child's school (*insert name of school*):** _____
9. When did your child **first start attending** this school? ____/____
   Month Year
10. What **grade** is your child in this year?_____ What is the name of his/her **teacher**? _____
11. Who is your child's primary care **physician**?
    Physician: _____
    Address: _____
    Telephone: ( ) _____
12. Has your child received **immunizations at other location**(s) other than his/her primary care provider office listed above in question 11? □Yes □ No
    12a. **If YES**, where did your child receive immunizations? (If more than one location, please provide all names)
    Name of facility: _____
    Address: _____
    Telephone: ( ) _____
13. Do you have an immunization record (shot card) available for your child? (Note-Please do not attach shot card)

□ Yes □ No

Please Check Your Immunization Record (Shot Card) to Answer the Next Section.

If you do not have a shot card, please fill in as much as you remember.

14. Has your child ever received the chickenpox vaccine before the current outbreak? (*There are 2 licensed vaccines for varicella: [1]VARIVAX, which became available in **1995** and [2]PROQUAD, which became available in **2005**)*

□ **Yes** If yes, number of vaccine doses: □ 1 dose □ 2 doses
Vaccination Date **Dose 1**:_____/_____/_____ Vaccine name: □Varivax □Proquad □Unknown
Month Day Year
Provider name : _____ Phone number: ( ) _____
Provider address:_____

Vaccination Date **Dose 2**:_____/_____/_____ Vaccine name: □Varivax □Proquad □Unknown
Month Day Year
Provider name: _____ Phone number: ( ) _____
Provider address:_____

□ **No** Please specify why your child has not ever received the chickenpox vaccine before the current outbreak.
(check all that apply)
□ My child already had chickenpox disease.
□ I have philosophical or religious beliefs that do not support childhood vaccination against disease.
□ My child's doctor/health care provider never offered the chickenpox vaccine for my child.
□ My child has a medical contraindication such that s/he cannot receive the chickenpox vaccine.
□ Other (please specify): _____

□ **Don't know**

(SURVEY CONTINUES ON BACK)

15. Does your child have any of the following long-standing health conditions?

☐ asthma ☐ eczema ☐ cancer (specify: _____) ☐ other (specify: _____)
☐ none ☐ don't know

15a. Does your child currently take any **medications** prescribed by a physician for this condition?

☐ Yes, please list medication names:_____

☐ No

16. Has your child had **chickenpox** disease since the start of this outbreak (*insert date*)? ☐ Yes ☐ No ☐ Don't know

16b. **Who diagnosed** the case of chickenpox? (Check one)

☐ Primary care provider or clinic listed in question ***11 or 12a*** (Please circle which one)

☐ Other physician or clinic, please specify_____

☐ Parents/friends/ relatives

☐ School nurse

☐ Other, please specify _____

17. Has your child ever had **chickenpox** disease prior to this outbreak (*insert date*)? ☐ Yes ☐ No ☐ Don't know

17a. **If YES**, at what **age**? _____ Years OR _____ Months

17b. **Who diagnosed** the case of chickenpox? (Check one)

☐ Primary care provider or clinic listed in question ***11 or 12a*** (Please circle which one)

☐ Other physician or clinic, please specify_____

☐ Parents/friends/ relatives

☐ School nurse

☐ Other, please specify _____

18. Other than the chickenpox mentioned above, did your child have any rashes, insect bites, bumps, spots, or blisters at any time after the **start of this outbreak *(insert date*)?** ☐ Yes ☐ No ☐ Don't know

19. How can we contact you if further information is needed?

Phone Number: ( )_____

Best time to call: _____

20. We would like to verify your child's vaccination history either from records kept at school or your child's health care provider (or vaccine provider, if different). All information will be kept strictly confidential and will be identified only by number in our files. ☐ I agree to allow verification of my child's vaccination history ☐ I do not agree

_____ _____

Signature of parent/caregiver Printed name of parent/caregiver

THANK YOU FOR COMPLETING THIS SURVEY!