CANTON CITY HEALTH DEPARTMENT CHILD TRAVEL CLINIC

Child's Last Name _____ First _____ Middle _____

Address_____ City_____ State____ Zip Code _____

County _____ Phone Number _____ Sex **(circle)** M F

Birth Date _____ Age _____ Height _____ Weight _____ Ethnicity: Hispanic □ Non-Hispanic □

Race: Asian/Pacific Islander □ Black □ Native Am/Alaskan Native □ White □ Other □

Parent/Guardian Name _____ Child's Doctor_____

Insurance Status:

___ I have **Buckeye** # _____ ___ I have **Medicaid** #_____

___ I have **CareSource** #_____ ___ I have private insurance that covers the cost of shots **100%**

___ I have **Molina Healthcare#**_____ Name/ID # _____

___ I have **Paramount** #_____ ___ I have private insurance that **does not** cover shots 100%

___ I have **United HealthCare** #_____ ___ I do not have any insurance

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1. Has your child been sick in the last two weeks? Yes _____ No _____
2. Does your child have any serious or chronic illness? If yes, what_____ Yes _____ No _____
3. Is your child taking any medicine at this time? If yes, what_____ Yes _____ No _____
4. Has your child received blood, blood products, or Gamma Globulin in the past six months? Yes _____ No _____
5. Has your child ever had:
   - a severe reaction to shots? Yes _____ No _____
   - a severe reaction to any medication? Yes _____ No _____
   - convulsions or seizures? Yes _____ No _____
   - Allergies? Specify_____ Yes _____ No _____
6. Does your child have allergies to: **(Circle your answer/or answers)** Yes _____ No _____
   a. chicken b. eggs c. bakers yeast d. gelatin
7. Has your child ever had chickenpox disease? Yes _____ No _____
   Has your child ever received the chickenpox vaccine? Yes _____ No _____
8. Has your child previously received immunizations at the Canton City Health Dept? Yes _____ No _____
   If no, where were shots given?_____
9. Has your child received vaccines anywhere since the last visit here? Yes _____ No _____
10. Has your child had a live vaccine in the past 28 days (MMR, Chickenpox, Flumist, Yellow Fever)? Yes _____ No _____
11. If your child is under 5 years old, is he/she enrolled in WIC? Yes _____ No _____
12. Are you the child's parent or legal guardian? Yes _____ No _____
13. Countries in order of arrival and length of stay in each Departure Date _____ Return Date _____

    1. _____ 2. _____ 3. _____

Reviewed by (Nurse): _____ Date: _____

I have received a copy of the Vaccine Information Statement(s) regarding the diseases and vaccines and understand there is a risk of slight to sever reaction with any vaccination. I also understand that this is a less risk than the risk to an unvaccinated person who could acquire one of these diseases. By signing this form, I acknowledge that I have received a copy of our Notice of Privacy Practices. I also grant permission for this record to be released to medical providers, health departments and schools to transmit the immunization history.

Signature_____ Date_____

Adolescent females ONLY

Date of last menstrual period: _____

I understand that certain vaccines should **NOT** be given to pregnant females. I also understand that the person getting such vaccines should avoid becoming pregnant for a four week period.

Signature of parent/guardian_____