Child Immunization Questionnaire

Has your child ever had:

Is the child sick today? NO____  YES____

A severe reaction to any shots or medicine? NO____  YES____

Convulsions, seizures or brain problem? NO____  YES____

Parent or Sibling with history of seizures? NO____  YES____

Any ongoing medical problems? NO____  YES____

An allergy to eggs, chicken, yeast, latex? NO____  YES____

Other allergies? ______________________ NO____  YES____

Has child had Chickenpox? NO____  YES____

A blood transfusion or immune globulin? NO____  YES____

Is your child taking any medication now? NO____  YES____

Older females only - Is your child pregnant? NO____  YES____

Received any other shots in past 4 weeks? NO____  YES____

Where else has the child received vaccinations ______________________

I have received a copy and have read or been read to me the information contained in the appropriate Vaccine Information Pamphlet or Important Information Statement about the disease(s) and vaccine(s) checked above. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) indicated on this record be given to me or the person named above for whom I am authorized to make this request. I have been advised to wait 15 minutes after the injection to monitor for signs and symptoms of an allergic reaction. I also grant permission for this record to be released/faxed to providers, health departments, school, day-care centers, community and state immunization registry databases and others as is necessary, per HIPAA Standards. I have been given the opportunity to read LCHD HIPAA Notice of Privacy Practices. Further this written release is good for 5 years, unless I notify LCHD in writing of something different.

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**** PARENTAL PERMISSION FOR NAMED PERSON TO BRING CHILD FOR IMMUNIZATIONS:

I give permission for (Name)____________________________________ to bring my child (Name)_____________________________ to receive all necessary vaccinations.

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Patient/Parent/Guardian Signature________________________________ Phone________________ Date____________

Revised: 10-02-2017