Clear Form

galion city HEALTH DEPARTMENT

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Child/Teen Immunization Checklist for Contraindications

Patient's Last Name: _____ First Name: _____ Middle: _____

Birth Date: _____ Age: _____ ☐ Male ☐ Female Your Relationship to Patient: _____

Current Weight: _____ Has the patient previously received vaccinations at the Galion City Health Department? ☐ No ☐ Yes

Insurance Status (List **ALL** current policies):

☐ I have Medicaid. Carrier: _____ Billing #/ID #: _____

☐ I have private insurance. Carrier: _____ Insured's Name: _____

Insured's Birth Date: _____ Billing #/ID #: _____ Group #: _____

Insured's Address (if different from patient): _____

Insured's Phone (if different from patient): _____ Does this insurance cover shots? ☐ Yes ☐ No

☐ I don't have health insurance.

Has **ANY** insurance information changed since your last visit, including the carrier, ID #s, etc.? ☐ Yes ☐ No

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1. Is the child sick today? ☐ No ☐ Yes ☐ Unknown
2. Does the child have allergies to medications, food, a vaccine component, or latex? ☐ No ☐ Yes ☐ Unknown
3. Has the child had a serious reaction to a vaccine in the past? ☐ No ☐ Yes ☐ Unknown
4. Does the child have a long-term health problem with lung, heart, kidney, or metabolic disease (e.g. diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Is he/she on long-term aspirin therapy? ☐ No ☐ Yes ☐ Unknown
5. If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child has wheezing or asthma in the past 12 months? ☐ No ☐ Yes ☐ Unknown
6. If your child is a baby, have you ever been told he or she has had intussusception? ☐ No ☐ Yes ☐ Unknown
7. Has the child, a sibling, or a parent had a seizure; has the child had a brain or nervous system problem? ☐ No ☐ Yes ☐ Unknown
8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem? ☐ No ☐ Yes ☐ Unknown
9. Does the child have a parent, brother, or sister with an immune system problem? ☐ No ☐ Yes
10. In the past 3 months, has the child taken any 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? ☐ No ☐ Yes
11. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or antiviral drug? ☐ No ☐ Yes ☐ Unknown
12. Is the child/teen pregnant or is there a chance she could become pregnant during the next month? ☐ No ☐ Yes
13. Has the child received vaccinations in the past 4 weeks? ☐ No ☐ Yes ☐ Unknown

I have received a copy of or access to the Vaccine Information Statement(s) regarding the diseases and vaccines. I grant permission for requested vaccine(s) to be given today. I understand that this information will be released to a state-wide immunization registry for immunization tracking, recall, and recording; unless I request otherwise. I understand that the patient should remain in the office for 15 minutes for observation in case of an adverse reaction.

If insurance is checked above, I authorize the Galion City Health Department to submit claims to my insurance company. I authorize payment of medical benefits to the Galion City Health Department for services administered. I further understand that I am responsible for any co-pays, co-insurance, deductibles, and/or non-covered charges as determined by my insurance carrier.

Signature: _____ Date: _____

For Health Department Use Only: ☐ **Public/VFC** ☐ **Private** Return Appointment Needed? ☐ Yes ☐ No

☐ DTap	☐ Varicella	☐ Pneumococcal	☐ Hepatitis B	☐ Kinrix/Quadracel (DTP, IPV)	☐ ProQuad (MMR, Varicella)
☐ IPV	☐ MMR	☐ Men ACWY	☐ HPV	☐ Pentacel (DTP, IPV, HIB)	☐ Influenza
☐ HIB	☐ Rotavirus	☐ Tdap/Td	☐ Hepatitis A	☐ MenB	☐ Other: _____