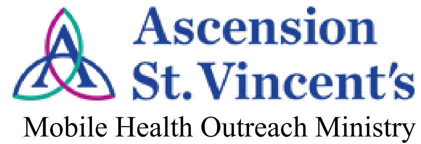

Childhood Immunization Information Questionnaire

Mobile Health Outreach Ministry

Student's name: *(first, MI, last)*: ____

Date of birth: ___________________ Age:______ Grade:______ Last 4 numbers of SSN:_________

Does the child have health insurance? *(For statistics only. We do not file insurance claims.)*
Please check one: __ No Insurance __ State Insurance (Medicaid, CMS, etc)
__ Other Insurance (private, Tricare, etc) __ Insurance doesn't cover immunizations

Please answer the following questions:

Question		
1. Has your child been seriously ill in the past two weeks? If yes, please explain	Yes	No
2. Has your child had immunizations of any kind in the last 2 months? What were they?	Yes	No
3. Did your child have any serious reactions to vaccines in the past? Please describe	Yes	No
4. Has your child, his siblings, or his parents ever had a seizure?	Yes	No
Does your child have brain or other nervous system problems? If yes, explain	Yes	No
5. Does your child have cancer, leukemia, or any other immune system problem?	Yes	No
Is any household member immuno-compromised or susceptible to disease?	Yes	No
6. Has your child had a transfusion, blood or blood products, or have been given Immune-(gamma) globulin or an antiviral drug in the past?	Yes	No
7. In the past 3 months, has your child taken cortisone, prednisone, other steroids, anti-cancer drugs, or had radiation treatment?	Yes	No
8. Is the child pregnant or is there a chance she could become pregnant during the next month?	Yes	No
9. Have you read the information sheets given to you concerning the immunization(s) your child is to receive today?	Yes	No
10. Does your child have allergies to any food, medicine, vaccine component, or latex? If yes, please list	Yes	No
11. Does your child have any problem after having shots, such as fainting spells? If yes, please list.	Yes	No
12. Do you have any question regarding the immunizations your child is to receive? If yes, please call St. Vincent's Mobile Pediatrics at 625-6809 to speak to a nurse.	Yes	No

STATEMENT: I have been given a copy and have read or had explained to me the information contained in the Vaccine Information Statement(s) about the disease(s) and the vaccine(s). I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated to be given to the person named above for whom I am authorized to make this request. I understand that Ascension St. Vincent's Mobile Health Outreach Ministry participates in the Florida SHOTS immunization registry. If you do not want your child to participate in the Florida registry or need more information, please call 625-6809.

Parent/Guardian Signature: ____

Relationship to Child: ________________________ **Today's Date:** ____________________________