Clinton County Health Department 211 N Jackson, Frankfort, IN 46041

3.

Signature of Parent/Guardian

ate	Parent's Name		
hild's First Name	Child's Last Name		

Did you bring your child's

Yes □ No □

immunization record with you?

1: 765-659-6385 F: 765-65	9-6387				
Street Address	City		Zip		
Date of Birth	Phone		Physician		
Child So	creening Questionnaire	YES	NO	Don't Know	
Is your child feeling ill today?					
2. Does your child have any allergies to many vaccine?	nedications (e.g. neomycin), food (e.g.eggs or gelatin), o	r			
3. Has your child ever had a serious reac	tion after receiving a vaccination?			1,10	
4. Does your child have a long-term health problem such as heart or lung disease, asthma, kidney disease, diabetes, anemia, or other blood disorder?					Changes? Date
5. Does your child have cancer, leukemia	a, AIDS, or an other immune disorder?				Chai
6. Does your child take cortisone, prednis radiation treatments?	sone, or other steroids, anticancer drugs or received				
7. Has your child ever had a seizure, brai	in or other nervous system problem?				
	ceived a transfusion of blood or blood products, or been tion (such as that used for HIV AIDS or Hep C)?				
9. Is your child/teen pregnant or is there a	a chance she could become pregnant in the next month?	?			Changes? Date
10. Has your child received a vaccination	in the past 4 weeks?				Char
I have been given a copy a vaccines my child is receivi	and have read or had explained to me the informing today.	ation ir	the VI	S statement fo	r the
My questions have been ar vaccine my child is receiving	nswered to my satisfaction. I believe that I under	rstand	the ben	efits and risks	of the

I consent to having my child's immunization record released to my child's health care providers, or school; I

Signature of Witness

consent to having my vaccines recorded in the CHIRP immunization registry.

Do you have insurance that pays for immunizations? Yes No

Consent and Record of Vaccine Administration

Dose/Date	Recipient Signature	Vaccine/Manufacturer	Lot#	Exp Date	Site	Given by:	VIS Date
1							
2							,
3							
Dose/Date	Recipient Signature	Vaccine/Manufacturer	Lot#	Exp. Date	Site	Given by:	VIS Date
1	and the state of the state of	0					
2							
3	de al como mos						
Dose/Date	Recipient Signature	Vaccine/Manufacturer	Lot#	Exp. Date	Site	Given by:	VIS Date
		Menactra					1/28/08
Dose/Date	Recipient Signature	Vaccine/Manufacturer	Lot#	Exp. Date	Site	Given by:	VIS Date
		Tdap					11/08/08
Dose/Date	Recipient Signature	Vaccine/Manufacturer	Lot#	Exp. Date	Site	Given by:	VIS Date
		Varicella (Chickenpox)					03/13/08
Dose/Date	Recipient Signature	Vaccine/Manufacturer	Lot#	Exp. Date	Site	Given by:	VIS Date
Dose/Date	Recipient Signature	Vaccine/Manufacturer	Lot#	Exp. Date	Site	Given by:	VIS Date
			1011111111				