

DATE: _____

CHILD FORM

Rev9/24

TIME: _____ INITIALS: _____

OFFICE STAFF ONLY

LAST NAME: _____ FIRST NAME: _____ MIDDLE: _____

(AS IT APPEARS ON THE BIRTH CERTIFICATE)

ADDRESS: _____ APT#: _____ CITY/STATE: _____

ZIP: _____ COUNTY: _____ COUNTRY OF BIRTH: _____

BIRTH DATE: _____ / _____ / _____ SOCIAL SECURITY NUMBER: _____ / _____ / _____ SEX: M / F
MTH DAY YR

RACE: WHITE BLACK AMERICAN INDIAN ALASKA NATIVE ASIAN OTHER

ETHNICITY: (CIRCLE) HISPANIC OR LATINO NOT HISPANIC OR LATINO

MOTHER'S FIRST NAME: _____ MOTHER'S MAIDEN NAME: _____

FATHER'S NAME: _____ Phone #: _____

RESPONSIBLE PARENT / GUARDIAN: _____ RELATIONSHIP: _____

DOES CHILD HAVE A PEDIATRICIAN? YES NO PEDIATRICIAN NAME: _____

YES	NO	MEDICAL HISTORY
		IS THE CHILD SICK TODAY?
		ANY ALLERGIES TO FOODS, MEDICATIONS, VACCINE COMPONENTS, OR LATEX?
		ANY SERIOUS REACTION TO VACCINES IN THE PAST?
		ANY HEALTH PROBLEMS WITH LUNG, HEART, KIDNEY, METABOLIC (DIABETES), ASTHMA OR BLOOD DISORDERS?
		ANY HEALTH PROBLEMS DUE TO LONG TERM ASPIRIN THERAPY?
		ANY CANCER, LEUKEMIA, AIDS, OR ANY OTHER IMMUNE SYSTEM DISORDER?
		ANY USE OF CORTISONE, PREDNISONE, STEROIDS OR ANTICANCER DRUGS, OR RADIATION TREATMENT IN THE PAST 3 MONTHS?
		BLOOD TRANSFUSIONS, OR BLOOD PRODUCTS, GAMMA GLOBULIN OR ANTIVIRAL DRUGS WITHIN THE PAST 12 MONTHS?
		HAS THE CHILD RECEIVED VACCINES DURING THE PAST 4 WEEKS?
		HAS THE CHILD HAD CHICKEN POX (VARICELLA)? YES OR NO APPROXIMATE MONTH, DATE, AND YEAR OF DISEASE: _____ / _____ / _____
		CHILD, SIBLING OR PARENT: ANY SEIZURES? CHILD: ANY BRAIN OR NERVOUS DISORDER?
		BABIES: HAS THE DOCTOR TOLD YOU THAT THE CHILD HAD INTUSSUSCEPTIONS?
		IF CHILD IS 2-4 YRS OLD: HAS THE CHILD BEEN DIAGNOSED WITH WHEEZING OR ASTHMA IN THE PAST 12 MONTHS?
		ANY MEDICAL CONDITIONS THAT WE NEED TO BE AWARE OF:
		FEMALES: IS THERE A CHANCE THAT YOUR DAUGHTER COULD BE PREGNANT OR BECOME PREGNANT DURING THE NEXT MONTH? LAST MENSTRUAL PERIOD?

NURSES SIGNATURE: _____

DATE: _____

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Our commitment here at CCNCPHD is to serve our customers with professionalism and care, being sure at all times to protect the privacy and security of all Protected Health Information. During the course of serving your interests it may be necessary to share information with other healthcare providers or business associates. The following are examples of instances where information may be shared:

- During treatment, we may find it necessary to acquire a laboratory analysis.
- For payment purposes, we may use the services of a billing service.
- During healthcare operations, we may need a second opinion and may consult with a subcontractor / physician, or need to share information between departments within the Health Department for future programs made available for improving patient care / health issues.

We here at CCNCPHD are committed to obeying all Federal, State, and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures that the ones listed above are needed, information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided for the law. If you have any questions or comments regarding your protected health information, feel free to contact our Compliance Officer. I have read and understand the above Notice of Privacy Practices.

I HAVE COMPLETED AND REVIEWED ALL INFORMATION ABOVE.

SIGNATURE: _____

DATE: _____

PRINT: _____