

Patient Name: _____

Date Form Completed: _____

CONTAGIOUS DISEASES:

Has your child ever had any of the following:

Please indicate date of illness if applicable

	<u>Date of Illness/ Patient Age</u>		<u>Date of Illness/ Patient Age</u>
Rubella (German Measles)	_____	Hepatitis	_____
Chicken Pox	_____	Mumps	_____
Measles (Regular)	_____	Whooping Cough	_____
Polio	_____	Diphtheria	_____
Tuberculosis	_____	Scarlet Fever	_____
Was illness verified by a physician? _____		Other	_____

Indicate Treatment: _____

VACCINATIONS AND IMMUNIZATIONS:

Give date of last immunization except as noted:

	<u>1st</u>	<u>2nd</u>	<u>3rd</u>	<u>4th</u>	<u>5th</u>	<u>Result and/ or Reaction</u>
DPT	_____	_____	_____	_____	_____	_____
Polio-Oral (OPV)	_____	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____	_____
Hepatitis B (HBV)	_____	_____	_____	_____	_____	_____
Hemophilus Influenza (HIB)	_____	_____	_____	_____	_____	_____
Tetanus	<u>TB Test/ Result:</u>				<u>Date Last Test:</u>	_____
Other	_____	_____	_____	_____	_____	_____

ALLERGIES AND DRUG SENSITIVITIES:

Is there any history of drug sensitivity? No Yes If yes, specify drug: _____

Describe symptoms experienced: _____

Is there any history of latex sensitivity: No Yes If yes, specify describe: _____

Is there any history of food or other allergies? No Yes If yes, please describe: _____

We, the parents/legal guardians, hereby (authorize / not authorize) the Shriners Hospitals for Children, Medical Staff, *(circle one)* to give any immunizations (including Polio Vaccine) which they may deem advisable.

Parents or Legal Guardian _____

Witness _____

Date _____

Signature