HEALTH HISTORY REQUEST

Please COMPLETE and RETURN this form to the school or your local health unit.
This information will be used to assess the immunization status of the school population.

CHILD'S NAME: ***SURNAME***	***GIVEN NAME(S)***	**BIRTH DATE:** YYYY MM DD	**CARE CARD NUMBER (PHN)**

PARENT/GUARDIAN	**PHONE** (HOME)	**PHONE** (OTHER)

ADDRESS	**CITY**	**POSTAL CODE**

PREVIOUS ADDRESS (within last 5 years). Needed to request health unit records.	**CITY/PROVINCE/COUNTRY**

SCHOOL ATTENDING IN SEPTEMBER	**GRADE**	**PREVIOUS SCHOOL**	**CITY**

RECORD OF IMMUNIZATION

*****Please attach a COPY of immunizations OR fill in the DATES of all past immunizations below*****

DPTP-Hib (Diphtheria, Pertussis, Tetanus, Polio, Haemophilus Influenza Type B)	MMR (Measles, Mumps, Rubella)	Hepatitis B	MeningococcalC Conjugate	Pneumococcal Conjugate	Varicella (Chickenpox)
#1-	#1-	#1-	#1-	#1-	Date of Vaccine:
#2-	#2-	#2-		#2-	
#3-		#3-		#3-	
#4-				#4-	Age of Disease:
DPTP –Kg Booster (Diphtheria, Pertussis, Tetanus, Polio)					
#5-					

List any other immunizations received below or on the back of this sheet

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ATTENTION: **If your child has any condition which may affect school performance, limit activity or require emergency care (eg. Epilepsy, diabetes, heart condition, asthma, severe allergy, etc.), it is the parents' responsibility to inform the school and complete any appropriate forms.**		
Signature of Parent/Guardian:	**Date Form Completed:**	**Public Health Nurse:**

Revised June 24,2008