SERVIZIO SANITARIO REGIONALE
EMILIA-ROMAGNA
Azienda Unità Sanitaria Locale della Romagna

Community Pediatrics

PREVACCINATION MEDICAL HISTORY RECORD

PLEASE, FILL OUT THE BACK OF THE FORM AS WELL

Vaccination(s): _____

I, the undersigned, _____ born on _____
(Surname and name of the parent)

I, the undersigned, _____ born on _____
(Surname and name of the parent)

Parents/Exercising parental responsibility/Guardian/Foster parent of _____
(Surname and name of the child)

Born in _____ on _____

Hereby declare that the child (**for infants over the age of six months, fill out from question 4 onward**):

1. **Was born preterm and/or with low birthweight**	Yes	No
2. **Suffered intussusception or has an uncorrected congenital malformation of the gastrointestinal tract that could predispose to intussusception**	Yes	No
3. **Has relatives (siblings, parents, or grandparents) with congenital immunodeficiency**	Yes	No
4. Was born to a mother who received immunosuppressive therapies during pregnancy or lactation	Yes	No
5. Is currently affected by a disease **If so**, please, specify _____	Yes	No
6. Is affected by diseases that compromise immunity (e.g., leukemia, cancer, HIV) or lives with people affected by those diseases **If so**, please, specify _____	Yes	No
7. Has received blood transfusions, blood products or immunoglobulin or antiviral medicines in the past year **If so**, please, specify _____	Yes	No
8. In the past 6 months, has taken medication on a regular basis (especially immunosuppressants) or underwent radiation therapy or dialysis **If so**, please, specify _____	Yes	No
9. Has experienced recurrent or persistent or severe infections **If so**, please, specify _____	Yes	No
10. Has had (or their parents or siblings have had) febrile seizures, epilepsy, or neurological disorders **If so**, please, specify _____	Yes	No
11. Has shown allergy to drugs, foods, latex, or other substances **If so**, please, specify _____	Yes	No
12. Has received any vaccinations in the last 4 weeks **If so**, please, specify _____	Yes	No
13. Had severe reactions to a previous vaccine dose **If so**, please, specify _____	Yes	No
14. Underwent surgery **If so**, please, specify _____	Yes	No
15. Is currently pregnant **(for women of childbearing age only)**	Yes	No

NOTES _____

SIGNATURE of the PARENTS: Parent _____ Parent _____

SIGNATURE of the person exercising parental responsibility/guardian/foster parent (*attach a copy of ID*) _____

Health conditions suitable for vaccination: ☐ Yes ☐ No

Date _____ **SIGNATURE and stamp of the Physician and Social worker / Nurse** _____

CONFIRMATION OF RECEIVED INFORMATION REGARDING THE ADMINISTRATION OF MANDATORY AND RECOMMENDED VACCINATIONS

I, the undersigned, _____ born on _____

I, the undersigned, _____ born on _____

parents/exercising parental responsibility/guardian/foster parent of _____

born in _____ on _____

HEREBY DECLARE THAT

- We have been informed of all details regarding the proposed treatment, the possible risks and complications (also in case of concomitant diseases), the possible consequences deriving from the refusal or avoidance of the proposed vaccination(s); we have understood the provided information and have received an answer to our requests for clarification
- We have been informed that we need to remain in the facility for 15 minutes after the vaccination and to monitor our child during the vaccination administration and the post-vaccination period
- We have been informed that the following **MANDATORY VACCINE(S)** is/are being administered today pursuant to Italian law July no. 119 of 31 July 2017 on mandatory vaccinations, of which we have received the information notes

O Poliomyelitis	O Hepatitis B
O Tetanus	O Haemophilus influenzae type b
O Diphtheria	O Measles, mumps, and rubella
O Pertussis	O Chickenpox *for children born as of 2017*

GIVE/DO NOT GIVE our consent TO THE ADMINISTRATION OF THE FOLLOWING RECOMMENDED VACCINATION(S), of which we have received the information notes

Rotavirus	O Give consent	O Do not give consent
Pneumococcal conjugate	O Give consent	O Do not give consent
Meningococcal B	O Give consent	O Do not give consent
Meningococcal ACWY	O Give consent	O Do not give consent
HPV 9-valent	O Give consent	O Do not give consent
Hepatitis A	O Give consent	O Do not give consent
Flu	O Give consent	O Do not give consent
Chickenpox *for children born before 2017*	O Give consent	O Do not give consent

SIGNATURE of both parents to be entered while physically at the vaccination site* or to be given to their legal representative in case they cannot be present.

Parent _____ Parent _____

SIGNATURE of the person exercising parental responsibility/guardian/foster parent (*attach a copy of ID*) _____

Date _____ SIGNATURE and stamp of the Physician and Social worker/ Nurse _____

*In case either parent is absent, the parent present at the vaccination site will fill out the self-declaration form