Donni Fleischaker
PRIMARY CARE & PEDIATRICS

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Pediatric Intake & Immunization

For patients under 18. To be completed by a parent or legal guardian.

CHILD'S FULL NAME _____ DATE OF BIRTH _____ SEX _____

HOME ADDRESS _____ TODAY'S DATE _____

PARENT / GUARDIAN

NAME _____ RELATIONSHIP _____ PHONE _____

EMAIL _____ SECOND PARENT / GUARDIAN & PHONE _____

BIRTH & DEVELOPMENT

BIRTH WEIGHT _____ WEEKS AT BIRTH _____

DELIVERY ☐ Vaginal ☐ C-section

COMPLICATIONS? ☐ No ☐ Yes

ANY DEVELOPMENTAL OR GROWTH CONCERNS? (WRITE "NONE" IF NONE)

IMMUNIZATIONS

ARE VACCINES UP TO DATE? ☐ Yes ☐ No ☐ Unsure

IMMUNIZATION RECORD ATTACHED? ☐ Yes ☐ Will bring

VACCINES DUE OR DECLINED (IF ANY)

☐ My child may qualify for the Vaccines for Children (VFC) program — please review eligibility with me.

HEALTH BACKGROUND

ALLERGIES (MEDICATION / FOOD) & REACTIONS

CURRENT MEDICATIONS

CHRONIC CONDITIONS / PAST SURGERIES OR HOSPITALIZATIONS

FAMILY MEDICAL HISTORY

SCHOOL / CHILDCARE

SCHOOL OR CHILDCARE NAME

GRADE

PHYSICAL NEEDED BY

PARENT / GUARDIAN SIGNATURE

DATE