

Please complete this survey and have your child return it to his or her teacher by **(insert date)**. ID Number: \_\_\_\_\_  
 All information will be kept strictly confidential. Your participation is completely voluntary; if you (for office use only)  
 do not want to answer any or all questions you don't have to. **Parents/Guardians with more than one child in school should fill out a separate survey for each child**

**Survey for Parents/Guardians of Children**

1. Name of person completing this form: \_\_\_\_\_
2. Relationship to child:  Parent  Other (please specify): \_\_\_\_\_
3. Child's Name: \_\_\_\_\_  
 Child's Address: \_\_\_\_\_  
 \_\_\_\_\_ Zip code \_\_\_\_\_  
 Parents' Telephone: (\_\_\_\_) \_\_\_\_\_
4. Child's date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Month Day Year
5. Child's age: \_\_\_\_\_ years
6. Sex of child:  Male  Female
7. Child's Race/Ethnicity: (Check one)  
 African-American  Asian/ Pacific Islander  Native American/Alaskan  Hispanic  
 White (Caucasian)  Other (please write): \_\_\_\_\_
8. **Child's school (insert name of school):** \_\_\_\_\_
9. When did your child **first start attending** this school? \_\_\_\_/\_\_\_\_  
 Month Year
10. What **grade** is your child in this year? \_\_\_\_\_ What is the name of his/her **teacher**? \_\_\_\_\_
11. Who is your child's primary care **physician**?  
 Physician: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Telephone: ( ) \_\_\_\_\_
12. Has your child received **immunizations at other location(s)** other than his/her primary care provider office listed above in question 11?  Yes  No  
 12a. **If YES**, where did your child receive immunizations? ( If more than one location, please provide all names)  
 Name of facility: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Telephone: ( ) \_\_\_\_\_
13. Do you have an immunization record (shot card) available for your child? (Note-Please do not attach shot card)  
 Yes  No

**Please Check Your Immunization Record (Shot Card) to Answer the Next Section.**

**If you do not have a shot card, please fill in as much as you remember.**

14. Has your child ever received the chickenpox vaccine before the current outbreak? (*There are 2 licensed vaccines for varicella: [1]VARIVAX, which became available in 1995 and [2]PROQUAD, which became available in 2005*)  
 **Yes** If yes, number of vaccine doses:  1 dose  2 doses  
 Vaccination Date **Dose 1**: \_\_\_\_/\_\_\_\_/\_\_\_\_ Vaccine name:  Varivax  Proquad  Unknown  
 Month Day Year  
 Provider name : \_\_\_\_\_ Phone number: ( ) \_\_\_\_\_  
 Provider address: \_\_\_\_\_  
 Vaccination Date **Dose 2**: \_\_\_\_/\_\_\_\_/\_\_\_\_ Vaccine name:  Varivax  Proquad  Unknown  
 Month Day Year  
 Provider name: \_\_\_\_\_ Phone number: ( ) \_\_\_\_\_  
 Provider address: \_\_\_\_\_  
 **No** Please specify why your child has not ever received the chickenpox vaccine before the current outbreak.  
**(check all that apply)**  
 My child already had chickenpox disease.  
 I have philosophical or religious beliefs that do not support childhood vaccination against disease.  
 My child's doctor/health care provider never offered the chickenpox vaccine for my child.  
 My child has a medical contraindication such that s/he cannot receive the chickenpox vaccine.  
 Other (please specify): \_\_\_\_\_  
 **Don't know**

**(SURVEY CONTINUES ON BACK)**

15. Does your child have any of the following long-standing health conditions?

- asthma  eczema  cancer (specify: \_\_\_\_\_)  other (specify: \_\_\_\_\_)  
 none  don't know

15a. Does your child currently take any **medications** prescribed by a physician for this condition?

- Yes, please list medication names: \_\_\_\_\_  
 No

16. Has your child had **chickenpox** disease since the start of this outbreak (insert date)?  Yes  No  Don't know

16b. **Who diagnosed** the case of chickenpox? (Check one)

- Primary care provider or clinic listed in question **11 or 12a** (Please circle which one)  
 Other physician or clinic, please specify \_\_\_\_\_  
 Parents/friends/ relatives  
 School nurse  
 Other, please specify \_\_\_\_\_

17. Has your child ever had **chickenpox** disease prior to this outbreak (insert date)?  Yes  No  Don't know

17a. **If YES**, at what **age**? \_\_\_\_\_ Years OR \_\_\_\_\_ Months

17b. **Who diagnosed** the case of chickenpox? (Check one)

- Primary care provider or clinic listed in question **11 or 12a** (Please circle which one)  
 Other physician or clinic, please specify \_\_\_\_\_  
 Parents/friends/ relatives  
 School nurse  
 Other, please specify \_\_\_\_\_

18. Other than the chickenpox mentioned above, did your child have any rashes, insect bites, bumps, spots, or blisters at any time after the **start of this outbreak (insert date)?**  Yes  No  Don't know

19. How can we contact you if further information is needed?

Phone Number: ( ) \_\_\_\_\_

Best time to call: \_\_\_\_\_

20. We would like to verify your child's vaccination history either from records kept at school or your child's health care provider (or vaccine provider, if different). All information will be kept strictly confidential and will be identified only by number in our files.  I agree to allow verification of my child's vaccination history  I do not agree

\_\_\_\_\_  
Signature of parent/caregiver

\_\_\_\_\_  
Printed name of parent/caregiver

**THANK YOU FOR COMPLETING THIS SURVEY!**

This document can be found on the CDC website at:

<http://www.cdc.gov/vaccines/vpd-vac/varicella/outbreaks/downloads/append-c-vci-survey.pdf>