Parker County Hospital District

Vaccine Consent Form

1115 Pecan Drive
Weatherford, Texas 76086
(817) 458 - 3254

Patient's Name: _____ Today's Date: _____

Patient's Birth Date: ____/____/_____ Patient's Age: _____ Gender: (M / F) Phone: _____

Address: _____ City / Zip: _____

REQUIRED INSURANCE INFORMATON

If the patient is 18 or under and not insured, please fill out the highlighted TVFC section on the back of this form

By completing the following insurance section, I authorize payment of medical benefits for any services provided. This information will be used for the purpose of evaluating and administering claims of benefits.

Please indicate the patient's coverage provider

☐ Aetna ☐ BCBS ☐ CIGNA ☐ Humana ☐ Tricare ☐ United

Subscriber (Policy Holder) Name:	Member ID (All letters & numbers):
Subscriber DOB:	Group #:

*** If you are filing insurance, please include a copy of your card with this consent form**

Please answer the following questions about the patient receiving the immunization(s) today:

1. Is the patient sick today? Yes____ No____
2. Does the patient have allergies to medications, food, or any vaccine component, or latex? Yes____ No____
   **IF yes, describe_____
3. Has the patient had a serious reaction to a vaccine in the past? Yes____ No____
   **IF yes, describe_____
4. Has the patient or an immediate family member (parent or sibling) had a seizure; has the patient had brain or other nervous system problems? Yes____ No____
   **IF yes, describe_____
5. Does the patient have cancer, leukemia, HIV/AIDS, or any other immune system problem? Yes____ No____
   **IF yes, describe_____
6. Does the patient have a parent or sibling with an immune system problem? Yes____ No____
   **IF yes, describe_____
7. In the past 1-3 months, has the patient taken medications that affect the immune system such as cortisone, prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments? Yes____ No____
   **If yes list medication and date of last treatment _____
8. Has the patient received transfusion of blood or blood products, or been given immune (gamma) gobulin or an antiviral drug in the past year? Yes____ No____
   **IF yes, describe_____
9. Does the patient have a blood or bleeding disorder such as thrombocytopenia or thrombocytopenia purpura? Yes____ No____
10. (If 20 years or younger) Is the patient on aspirin therapy? Yes____ No____
11. Is the patient pregnant or could become pregnant in the next month? Yes____ No____
12. Has the patient received a vaccination in the past 4 weeks? Yes____ No____
    **IF yes, please list vaccine(s)_____

Consent for Immunization

I hereby give authorization for PCHD to administer required vaccinations to myself/child. I release Parker County Hospital District, its employees, representatives and agents from any liability for giving myself/child vaccinations. I accept responsibility for seeking medical attention for any problems associated with receiving the vaccines. I am also aware that the receiver of this vaccine is currently not pregnant and should not become pregnant within 4 weeks of receiving vaccines. I acknowledge that I have received all vaccine information sheets for the vaccines given. I have had the opportunity to have all my questions answered. I understand that this consent is valid for 6 months and I will make PCHD/ school aware of any changes prior to being vaccinated.

Patient/Parent signature:_____ Date:____/____/_____

PCHD Staff signature:_____ Date:____/____/_____

TEXAS Health and Human Services | Texas Department of State Health Services

Texas Immunization Registry (ImmTrac2)
Minor Consent Form

A parent, legal guardian or managing conservator must sign this form if the client is younger than 18 years of age.

Child's First Name _____ Child's Middle Name _____ Child's Last Name _____

Child's Date of Birth (mm/dd/yyyy) _____/_____/_____ Child's Gender: ☐ Male ☐ Female Telephone _____-_____-_____ Email address _____

Child's Address _____ Apartment # / Building # _____

City _____ State _____ Zip Code _____ County _____

Mother's First Name _____ Mother's Maiden Name _____

Race (select all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race ☐ Recipient Refusal

Ethnicity (select only one)

☐ Hispanic or Latino ☐ Other
☐ Not Hispanic or Latino

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). The Texas Immunization Registry is a secure and confidential service that consolidates and stores your child's (younger than 18 years of age) immunization records. With your consent, your child's immunization information will be included in the Texas Immunization Registry. Doctors, public health departments, schools, and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed. For more information, see Texas Health and Safety Code Sec. 161.007 (d). **https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.007.**

Consent for Registration of Child and Release of Immunization Records to Authorized Persons/Entities

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the Texas Immunization Registry. Once in the Texas Immunization Registry, the child's immunization information may by law be accessed by a public health district or local health department, for public health purposes within their areas of jurisdiction, a physician, or other health-care provider legally authorized to administer vaccines, for treating the child as a patient, a state agency having legal custody of the child, a Texas school or child-care facility in which the child is enrolled, and a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child. I understand that I may withdraw this consent at any time by submitting a completed Withdrawal of Consent Form in writing to the Texas Department of State Health Services, Texas Immunization Registry.

State law permits the inclusion of immunization records for First Responders and their immediate family members in the Texas Immunization Registry. A "First Responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency. An "immediate family member" is defined as a parent, spouse, child, or sibling who resides in the same household as the First Responder. For more information, see Texas Health and Safety Code Sec. 161.00705. https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.00705.

Please mark the following box to indicate whether your child is an Immediate Family Member of a First Responder: ☐ **I am an IMMEDIATE FAMILY MEMBER of a First Responder.**

By my signature below, I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas Immunization Registry.

Parent, legal guardian, or managing conservator:

* Printed Name _____ * Signature _____ * Date _____

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.texas.gov for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Contact Information: Questions? Tel: (800) 348-9158 • Fax: (512) 776-7790 • **www.ImmTrac.com**
Texas Department of State Health Services • Immunizations
Texas Immunization Registry – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

Texas Department of State Health Services
Immunizations
Stock No. C-7
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Scan this QR code, with your phone, to access information regarding the vaccine(s) being given.

Texas Vaccines for Children (TVFC) Program Patient Eligibility Screening Record

A record of all children 18 years of age or younger who receive immunizations through the Texas Vaccines for Children (TVFC) Program must be kept in the health care provider's office for a minimum of five (5) years. The record may be completed by the parent, guardian, individual of record, or by the health care provider. TVFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure eligibility status for the program. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines under the TVFC Program.

1. **Child's Name:** _____ (Last Name) _____ (First Name) _____ (MI)
2. **Child's Date of Birth:** _____/_____/_____ (MM DD YYYY)
3. **Parent, Guardian, or Individual of Record:** _____ (Last Name) _____ (First Name) _____ (MI)
4. **Please check the catagory that applies:**
   - ☐ **is enrolled in Medicaid** _____ **Medicaid Number** _____/_____/_____ **Date of Eligibility**
   - ☐ **is an American Indian or an Alaskan Native**
   - ☐ **Does not have health Insurance**
   - ☐ **is enrolled in the Children's Health Insurance Plan CHIP**
   - ☐ **is underinsured:**
     1. **has commercial insurance, but coverage does not include vaccines**
     2. **commercial insurance covers only select vaccines**
   - ☐ **Has private insurance that covers vaccines**