Parker County Hospital District

1121 Pecan Street
Weatherford, Texas 76086
817-599-1229

Clinic Location:_____ Clinic Date:_____

Patient Name:_____ Birth Date:_____

Address:_____ City/ State/ zip_____

Phone: ( )_____ Alt. Phone: ( ) _____

BEFORE getting an **Influenza** vaccine please check YES or NO to the following questions:

Did the person receiving the shot today receive the H1N1 vaccine in 2009– 2010? __Yes __No

Have you received the seasonal Flu vaccine before? __Yes ___No

Are you pregnant or breast feeding? (If yes, you will need permission from your doctor to receive the flu vaccine) ___Yes ___No

Do you have fever today? ___ Yes ___No

Do you have an allergy to chicken eggs, egg products, or latex? ___Yes ___No

Is the person to be vaccinated have cold or flu symptoms today? ___Yes __No

Have you ever had a neurological disorder or have you been diagnosed with Guillain– Barre' Syndrome? ___Yes __No

Do you have any health problems or allergic disorders that requires you to currently see a physician? ___Yes __No
If yes explain_____

Do you have a known allergy to thimerosal, a derivative of mercury? (i.e. merthiolate, eye contact solution) __Yes __No

Has the person receiving the vaccination had a severe reaction after receiving any vaccinations? __Yes ___No

I am providing this consent form to Parker County Hospital District in order that I may be given the influenza vaccination. I have read and understand the information I have received concerning the possible benefits and side effects of the influenza vaccinations. I hereby acknowledge that based on the information presented to me, I am eligible to receive the influenza vaccine on this date. I am feeling well today and I have not recently had fever. I understand that no assurance can be given that the influenza vaccination will give me immunity from contracting any strain of influenza.
I hereby acknowledge that I have received a copy of the Vaccine Information Sheet on the 2010 Influenza .
I release Parker County Hospital District, its employees, representatives and agents from any liability for giving me the influenza vaccination.
I accept responsibility for seeking medical attention for any problems associated with my receiving the vaccine. I have had the opportunity to have all my questions answered.

Signature:_____
Date:_____

Consent for Immunization of a Minor: I, (parent)_____ give permission and consent for (child) _____DOB___/___/_____ to receive the 2010 Seasonal Influenza Vaccine.

Parent Signature:_____ **Date:**____/____/____

Staff Signature:_____**Date:**____/____/____

TEXAS VACCINES FOR CHILDREN PROGRAM (TVFC)
PATIENT ELIGIBILITY SCREENING RECORD

CLINIC USE ONLY:
TVFC Eligible:
☐ Yes ☐ No

Purpose: To determine eligibility and the source of funds for the Texas Department of State Health Services to be reimbursed for vaccines. A record must be kept in the office of the health-care provider that reflects the status of all children 18 years of age or younger who receive immunizations through the Texas Vaccines for Children Program. The record may be completed by the parent, guardian, or individual of record. This same record may be used for all subsequent visits as long as the child's eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines.

Date of Screening: _____

Child's Name:

_____
Last Name First Name MI

Child's Date of Birth: ____/____/____
mm/dd/yy

Parent/Guardian/Individual of Record:

_____
Last Name First Name M

Provider's/Clinic's Name:

_____

Please select one of the following categories (check the first category that applies, check only one) to determine if the child is TVFC eligible:

- ☐ (a) is enrolled in Medicaid, or
- ☐ (b) does not have health insurance, or
- ☐ (c) is an American Indian, or
- ☐ (d) is an Alaskan Native, or
- ☐ (e) is a patient who receives benefits from the Children's Health Insurance Plan (CHIP), or
- ☐ (f) is underinsured (has health insurance that **Does Not** pay for vaccines, has a co-pay or deductible the family cannot meet, or has insurance that provides limited wellness or prevention coverage), or
- ☐ (g) is a patient who is served by any type of public health clinic and does not meet any of the above criteria (a-f), or
- ☐ (h) has private insurance, or is paying for services.

Signature: _____ Date: _____

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.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
IMMUNIZATION REGISTRY (ImmTrac)
CONSENT FORM

ImmTrac
Texas Immunization Registry

(Please print clearly)

For Clinic/Office Use

Child's Last Name

Child's First Name

Child's Middle Name

Child's Date of Birth **Children under 18 years only.*

Child's Gender: ☐ **Male** ☐ **Female**

Child's Address

Apartment #

Telephone

City

State

Zip Code

County

Mother's First Name

Mother's Maiden Name

ImmTrac, the Texas immunization registry, is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates and stores your child's (under 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac. Doctors, public health departments, schools and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed.

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

Consent for Registration of Child and
Release of Immunization Records to Authorized 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 state's central immunization registry ("ImmTrac"). Once in ImmTrac, 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;
- 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 to include information on my child in the ImmTrac Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac Group – MC 1946, P.O. Box 149347, Austin, Texas 78714-9347.

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

_____ _____
Date **Signature**

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.state.tx.us** for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

Questions? (800) 252-9152 • (512) 458-7284 • www.ImmTrac.com
Texas Department of State Health Services • ImmTrac Group – MC 1946 • P.O. Box 149347 • Austin, TX 78714-9347

Stock No. C-7
Revised 07/22/08

TEXAS Department of State Health Services

PROVIDERS REGISTERED WITH ImmTrac** – Please enter client information in ImmTrac and **affirm** that consent has been granted. **DO NOT fax to ImmTrac. Retain this form in your client's record.