1130 Pecan Street
Weatherford, Texas 76086
(817) 341 - 2520

Parker County Hospital District

Clinic Location: ____________ **Clinic Date:** ____________

Patient Name: ____________ **Birth Date:** ____________

Address: ____________ **City/ State /Zip:** ____________

Phone Number: ____________

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 had health problems with asthma, lung disease, heart disease, kidney disease, metabolic disease (diabetes), or blood disease? Yes____ No____
   **IF yes, describe____________
5. If the patient is between the ages of 2 and 4 years, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months? Yes____ No____
6. Has the patient had a seizure, or other nervous system problems? Yes____ No____
   **IF yes, describe____________
7. Does the patient have cancer, leukemia, AIDS, or any other immune system problem? Yes____ No____
   **IF yes, describe____________
8. Has the patient taken cortisone, prednisone, other steroids, or anticancer drugs or had radiation treatment in the past 3 months? Yes____ No____
   **IF yes, describe____________
9. 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____________
10. Is the patient pregnant or could become pregnant in the next month? Yes____ No____
11. Has the patient received a vaccination in the past 4 weeks? Yes____ No____

Did you bring the patient's immunization record with you today? Yes____ No____

Consent for Immunization of a Minor:

I, (parent/guardian)____________give permission and consent for (child)____________

DOB____/____/________ to receive the appropriate immunization needed.

Mother's Maiden Name: ____________

Patient/Parent signature:____________ **Date:**____/____/________

PCHD Staff signature:____________ **Date:**____/____/________

Texas Department of State Health Services
IMMUNIZATION REGISTRY (ImmTrac)
CONSENT FORM

ImmTrac
Texas Immunization Registry

Departamento Estatal de Servicios de Salud
REGISTRO DE INMUNIZACIÓN (ImmTrac)
Formulario de CONSENTIMIENTO

(Please type or print clearly.) *(Sírvase escribir claramente a maquina o con letra de molde.)*

Child's Last Name / Apellido del niño(a)

Child's First Name / Nombre del niño(a)

Child's Middle Name / Segundo nombre del niño(a)

Child's Date of Birth / Fecha de nacimiento del niño(a)
** Children under 18 years only / Solamente niños menores de 18 años*

ImmTrac, the Texas immunization registry, is a free service of the Texas Department of State Health Services. 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 consent below, I register my child in the Texas Department of State Health Services immunization registry and authorize the registry to include my child's information in the registry and to release past, present, and future immunization records on my child to a parent of the child and any of the following:

- public health district or local health department;
- physician or health care provider;
- insurance company, health maintenance organization or payor;
- school or child care facility in which the child is enrolled and/or
- state agency having legal custody of the child.

I understand that I may withdraw the 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, Immunization Registry, 1100 West 49th Street, Austin, Texas 78756.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas immunization registry.
Al firmar abajo, YO AUTORIZO el consentimiento para registrarlo. Deseo INCLUIR la información de mi niño en el registro de inmunización de Texas.

Parent, legal guardian, or managing conservator:
Alguno de los padres, tutor legal o administrador de bienes: Printed Name / Escriba con letra de molde

Date / Fecha Signature / Firma

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

CLINIC USE ONLY:
TVFC Eligible:
☐ Yes ☐ No

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. If patient eligibility changes, a new form must be completed. While verification of responses is not required, it is necessary to retain this or a similar eligibility screening record for each child receiving vaccines under the TVFC Program.

Please check the first category that applies; check only one.

- ☐ (a) is enrolled in Medicaid, or
- ☐ (b) does not have health insurance (uninsured), 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)
- ☐ (f) is underinsured: 1) has commercial (private) health insurance, but coverage does not include vaccines; or 2) insurance covers only selected vaccines (TVFC-eligible for non-covered vaccines only); or 3) insurance caps vaccine coverage at a certain amount. Once that coverage amount is reached, the child is categorized as underinsured.

Fully, privately insured children are no longer eligible for TVFC vaccine.

- ☐ (g) has private insurance that covers vaccines (not TVFC eligible).

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 Branch

TEXAS Department of State Health Services

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