

TARRANT COUNTY PUBLIC HEALTH Consent for Immunization

IMPORTANT: Tarrant County Public Health (TCPH) does not deny services based on the patient's ability to pay. Any outstanding balances on your account will not be referred to an outside collection agency. The source of reimbursement will not affect the clinical care you receive. If at any point during your visit you would like to speak to a manager regarding your concerns, please do not hesitate to ask.

Patient's Information (Please Print)

Last Name	First Name	Middle Name	Suffix	Date of Birth <small>____/____/____ Month Day Year</small>	Age
Address	City and County	State	Zip Code	Home/Cell Phone	Email
Preferred Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Ethnicity <input type="checkbox"/> Hispanic/ Latino <input type="checkbox"/> Not Hispanic/ Latino <input type="checkbox"/> Decline to answer		Race <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Other	

Parent/Guardian or Emergency Contact Information

Last Name	First Name	Middle Name	Maiden Name
Date of Birth <small>____/____/____ Month Day Year</small>	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Home/Cell Phone	Relationship to Patient

Eligibility

<input type="checkbox"/> Medicaid #	<input type="checkbox"/> CHIP #	<input type="checkbox"/> Alaskan Native	<input type="checkbox"/> No Insurance
<input type="checkbox"/> American Indian	<input type="checkbox"/> Private Insurance (Not VFC eligible-will not receive VFC vaccines at school)	<input type="checkbox"/> Underinsured (Not insured for immunizations)	

Initial one:

* _____ I declare that I do have insurance coverage, and fully understand that Tarrant County Public Health (TCPH) will bill my insurance for rendered services. Furthermore, I am aware that the insurance reimbursement will be paid directly to TCPH. I understand I will be responsible for any charges not covered by my insurance.

* _____ I declare that I do not have insurance coverage for vaccines, and I am fully responsible for the charges incurred as a self-pay client for rendered services. If a claim is filed later for these charges, I understand that I will not receive a refund from TCPH.

Screening Checklist for Today's Immunizations

1. Is the child to be vaccinated sick today?	Yes	No
2. Does the child have allergies to medications, eggs, food, a vaccine component, or latex?	Yes	No
3. Has the child had a serious reaction to a vaccine or the intranasal influenza (FluMist) vaccine in the past?	Yes	No
4. Does the child have a health problem with lung, heart, kidney, or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she receiving aspirin therapy or aspirin-containing therapy?	Yes	No
5. If the child to be vaccinated 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. If your child is a baby, have you ever been told he or she has had intussusception?	Yes	No
7. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem; or, in the past 3 months, has the person/ child taken medications that weaken their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?	Yes	No
8. Has the child, a sibling, or a parent had a seizure; has the person/child had brain or other nervous system problems? Has the person/child ever had Guillain-Barré syndrome?	Yes	No
9. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	Yes	No
10. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g. an isolation room of a bone marrow transplant unit)?	Yes	No
11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	Yes	No
12. Has the child received vaccinations in the past 4 weeks?	Yes	No

Date of chickenpox illness: → _____ (month/year) or Date of chickenpox immunization: → _____

VACCINATION CONSENT: I received a copy of the Vaccine Information Statement for each vaccine. I know the risks of the disease each vaccine prevents. I know the benefits and risks of each vaccine. I have had a chance to ask questions about the diseases, the vaccines, and how the vaccines are given. I am an adult who can legally consent for the person named above to get vaccines. I have received information about the HIPAA privacy notification. **By signing this form, I hereby attest that this information is true and correct.**

Signature: _____ Date: _____ Signature _____ Date _____
Parent, Guardian, or Managing Conservator School Nurse

PARENT: Initial each individual vaccine(s) you want your child to be given.

Parent Initials	Vaccine to be given	Date given	Series	Mfg.	Lot #	VIS Date	Site	Given By
*	TDAP							
*	MCV							
*	HPV							

TARRANT COUNTY PUBLIC HEALTH Consentimiento para vacunación

IMPORTANTE: El Departamento de Salud Pública del Condado de Tarrant (TCPH) no niega los servicios en función de la capacidad de pago del paciente. Cualquier saldo pendiente en su cuenta no se remitirá a una agencia de cobranza externa. La fuente de reembolso no afectará la atención clínica que reciba. Si en algún momento durante su visita desea hablar con un gerente sobre sus preocupaciones, no dude en preguntar.

Información del Paciente (Por favor imprima)

Apellido	Nombre	Segundo nombre	Sufijo	Fecha de nacimiento ____/____/____ Mes Dia Año	Edad
Dirección	Ciudad y Condado	Estado	Código postal	Número de teléfono	Correo electrónico
Idioma preferido <input type="checkbox"/> inglés <input type="checkbox"/> español <input type="checkbox"/> Otro	Genero <input type="checkbox"/> Masculino <input type="checkbox"/> Femenino	Origen Etnico <input type="checkbox"/> Hispano/ Latino <input type="checkbox"/> No Hispano/ Latino <input type="checkbox"/> Prefiere no responder		Raza <input type="checkbox"/> Blanco <input type="checkbox"/> Indio Americano o Nativo de Alaska <input type="checkbox"/> Nativo de Hawaii/ Isleño del pacífico <input type="checkbox"/> Asiático <input type="checkbox"/> Negro o Afroamericano <input type="checkbox"/> Otro	

Información del Padre/Guardian o Contacto de Emergencia

Apellido	Nombre	Segundo Nombre	Nombre de Soltera
Fecha de Nacimiento ____/____/____ Mes Dia Año	Genero <input type="checkbox"/> Masculino <input type="checkbox"/> Femenino	Número de teléfono	Relación al paciente

Elegibilidad

<input type="checkbox"/> Medicaid #	<input type="checkbox"/> CHIP #	<input type="checkbox"/> Alaskan Native	<input type="checkbox"/> No Insurance
<input type="checkbox"/> American Indian	<input type="checkbox"/> Private Insurance (Not VFC eligible-will not receive VFC vaccines at school)		<input type="checkbox"/> Underinsured (Not insured for immunizations)

Declaro que tengo cobertura de seguro médico y entiendo completamente que Tarrant County Public Health (TCPH) facturará a mi seguro por servicios prestados. Además, soy consciente de que el reembolso del seguro se pagará directamente a TCPH. Entiendo que seré responsable de cualquier cargo no cubierto por mi seguro.

Declaro que no tengo cobertura de seguro médico para vacunas, y soy totalmente responsable de los cargos como cliente que paga por cuenta propia por los servicios prestados. Si se presenta un reclamo más tarde por estos cargos, entiendo que no recibiré un reembolso de TCPH.

Lista de verificación para las vacunas de hoy

1. ¿Está enfermo el niño(a) que se va a vacunar hoy?	Si	No
2. ¿El niño(a) tiene alergias a medicamentos, huevos, alimentos, o un componente de vacuna o látex?	Si	No
3. ¿Ha tenido el niño(a) alguna reacción grave a una vacuna o a la vacuna intranasal contra la influenza (FluMist) en el pasado?	Si	No
4. ¿Tiene el niño(a) un problema de salud o enfermedad pulmonar, cardíaca, renal o metabólica (p. ej., diabetes), asma o un trastorno de la sangre? ¿Está recibiendo terapia con aspirina o terapia que contiene aspirina?	Si	No
5. Si el niño(a) que se va a vacunar tiene entre 2 y 4 años de edad, ¿Algún proveedor de atención médica le ha dicho que el niño(a) ha tenido sibilancias o asma en los últimos 12 meses?	Si	No
6. Si su niño(a) es un bebé, ¿alguna vez le han dicho que ha tenido una intususcepción?	Si	No
7. ¿Tiene el niño(a) cáncer, leucemia, VIH/SIDA o cualquier otro problema del sistema inmunitario; o, en los últimos 3 meses, ¿ha tomado el niño(a) medicamentos que debilitan su sistema inmunológico, como cortisona, prednisona, otros esteroides o medicamentos contra el cáncer, o ha recibido tratamientos de radiación?	Si	No
8. ¿Ha tenido el niño(a), un hermano(a) o uno de los padres una convulsión?; ¿Ha tenido el niño(a) problemas cerebrales u otros problemas del sistema nervioso? ¿El niño(a) ha tenido alguna vez el síndrome de Guillain-Barré?	Si	No
9. En el último año, ¿Ha recibido el niño(a) una transfusión de sangre o productos sanguíneos, o recibió inmunoglobulina (gamma) o un medicamento antiviral?	Si	No
10. El niño(a) que se va a vacunar: ¿Vive o espera tener contacto cercano con una persona cuyo sistema inmunitario está gravemente comprometido y que debe estar en aislamiento protector (p. ej., una sala de aislamiento de una unidad de trasplante de médula ósea)?	Si	No
11. ¿Está embarazada la niña/adolescente o existe la posibilidad de que quede embarazada durante el próximo mes?	Si	No
12. ¿Ha recibido el niño(a) vacunas en las últimas 4 semanas?	Si	No
13. Fecha de la enfermedad de varicela: → _____ (mes/año) o Fecha de vacunación contra la varicela: → _____		

CONSENTIMIENTO DE VACUNAS: Recibí una hoja con información sobre cada vacuna. Conozco los riesgos de las enfermedades que cada vacuna previene. Conozco los beneficios y riesgos de cada vacuna. He tenido la oportunidad de hacer preguntas sobre las enfermedades, las vacunas, y como son administradas las vacunas. Soy adulto, y legalmente soy la persona quien puede dar el consentimiento para que esta persona reciba las vacunas. He recibido información sobre la notificación de privacidad de HIPAA. Al firmar este formulario hoy doy fe de que esta información es verdadera y correcta.

Firma: _____ **Fecha:** _____ **Signature:** _____ **Date** _____
Padre, tutor o custodio administrador School Nurse

PADRE: Escriba sus iniciales en cada vacuna individual que desee que le administren a su hijo.

Iniciales	Vaccine to be given	Date Given	Series	Mfg.	Lot #	VIS Date	Site	Given by
✕	TDAP							
✕	MCV							
✕	HPV							



Texas Immunization Registry (ImmTrac2)
Minor Consent Form



First Name Middle Name Last Name
Date of Birth (mm/dd/yyyy) Child's Sex: Male Female Telephone Email address

Address Apartment # / Building #

City State Zip Code County

Mother's First Name Mother's Maiden Name

Race (select all that apply) Ethnicity (select only one)
American Indian or Alaska Native Asian Black or African-American Hispanic or Latino
Native Hawaiian or Other Pacific Islander White Other Race Not Hispanic or Latino
Recipient Refused Other

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). ImmTrac2 is a secure and confidential service that consolidates and stores your immunization records.

Consent for Registration of Release of Immunization Records to Authorized Persons/Entities
I understand that, by granting the consent below, I am authorizing release of my immunization information to DSHS and I further understand that DSHS will include this information in ImmTrac2.

State law permits the inclusion of immunization records for first responders and their immediate family members in ImmTrac2. A "first responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency.

Please mark the box below to indicate whether you are an immediate family member of a first responder.
I am 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 information in the Texas Immunization Registry.
Individual (or individual's legally authorized representative):
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.

PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in the Texas Immunization Registry and affirm that consent has been granted. DO NOT fax to ImmTrac2. Retain this form in your client's record.

Questions? Tel: 800-252-9152 • Fax: 512-776-7790 • https://www.dshs.texas.gov/immunize/immtrac/
Texas Department of State Health Services • Immunizations • Texas Immunization Registry – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

