# TEXAS CHILDREN'S MOBILE CLINIC PROGRAM CONSENT FORM A

***Send your child's vaccine record with your child on the day of the vaccine clinic or we will only assess school and IMMTRAC records.***

**Information about *child* to receive vaccination (Complete in blue or black ink):**

| Last Name: | First Name: | Middle Initial: | Date of Birth/Age: |
|---|---|---|---|
| Address: | City: | Zip Code: | Male □ Female □ |
| Parent/Guardian/Self (if patient ≥18 years) Name: | Parent/Guardian Phone #: | Alternate Parent/Guardian Phone #: | |

**Name of person completing this form and person's relationship to patient:**

Name: □ Self (if 18 or older) □ Parent/Guardian □ Other, Please specify_____

## Screening Questionnaire for My Child. Please mark the correct response for each statement.

*NOTE: If child appears sick on the day of the immunization clinic, we will call the parent/guardian before immunizing child.*

| | | |
|---|---|---|
| Has your child had a serious reaction to a vaccine before? **If Yes, explain:** | □ Yes | □ No |
| Does the child or a family member have cancer, leukemia, HIV/AIDS, or any other immune system problems? **If Yes, explain:** | □ Yes | □ No |
| Has the child, sibling, or parent had a seizure OR has the child had brain or other nervous system problems? **If Yes, explain:** | □ Yes | □ No |
| Does your child have an allergy to eggs or to a component of the influenza vaccine? | □ Yes | □ No |
| Has the person to be vaccinated ever had Guillain-Barré syndrome? | □ Yes | □ No |

**PARENT OR GUARDIAN: Please initial ALL that apply (FIRST 2 MUST BE INIITIALED)**

| | |
|---|---|
| ! **Healthcare Worker Exposure: I understand that if a provider is exposed to my child's blood, the provider will take a small amount of blood to test for certain infections. I understand the results will be confidential** | ✘ _____ **Initials** |
| ! **Privacy: I received the Texas Children's Hospital Integrated Delivery System Notice of Privacy Practices. It explains how information in my child's medical or billing records can be used or disclosed.** | ✘ _____ **Initials** |
| **Human Papilloma Virus Vaccine:** I have been given a copy and have read the information in the "Vaccine Information Statement" dated 12/2/16 (VIS) and want the HPV vaccine to be given to my child. | ✘ _____ **Initials** |
| **Hepatitis A:** I have been given a copy and have read the information in the "Vaccine Information Statement" dated 07/20/16 (VIS) and want the Hepatitis A vaccine to be given to my child. | ✘ _____ **Initials** |
| **Tdap Vaccine (Tetanus, Diphtheria, Pertussis):** I have been given a copy and have read the information in the "Vaccine Information Statement" dated 02/24/15 (VIS) and want the Tdap vaccine to be given to my child | ✘ _____ **Initials** |
| **Meningococcal Vaccine MCV4:** I have been given a copy and have read the information in the "Vaccine Information Statement" dated 03/31/16 (VIS) and want the MCV4 vaccine to be given to my child. | ✘ _____ **Initials** |
| **Influenza Inactivated:** I have been given a copy of and have read the information in the "Vaccine Information Statement" dated 08/07/15(VIS) and want the Influenza vaccine to be given to my child. | ✘ _____ **Initials** |

**By providing my signature, I acknowledge the above statements are true and give consent where initialed.**

✘ _____ _____

**Signature** **Date**

**Provider Use Only**

| Vaccine | Site | Manufacturer/Lot # | Exp. Date |
|---|---|---|---|
| **HPV** | | | |
| **Hep A** | | | |
| **Tdap** | | | |
| **MCV4** | | | |
| **Influenza** | | | |

Provider Signature:_____

Date: _____

Updated 12/2017