Parker County Hospital District
Outreach

COVID Vaccine Consent Form

1115 Pecan Drive Weatherford, Texas 76086
www.pchdtx.gov (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

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 ☐ Blue Cross Blue Shield ☐ CIGNA ☐ Humana ☐ United

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

TRICARE Military Member's Information:	Policy Holder Name:	DOB:	SS#:	DOD #:
		____/___/____	_____	_____

Please answer the following questions about the patient receiving the immunization 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 ever felt dizzy or faint before, during or after receiving a shot? Yes____ No____
5. Is the patient moderately or severely immunocompromised? Yes____ No____
6. Has the patient ever been diagnosed with multi system inflammatory syndrome as a child or an adult? Yes____ No____
7. Has the patient ever been diagnosed with myocarditis or pericarditis within 3 weeks after receiving a dose of **ANY** COVID-19 vaccine? Yes____ No____
8. Has the patient received a COVID vaccination in the past 8 weeks? Yes____ No____

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 certain live virus 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 aware of any changes prior to being vaccinated.

Scan this QR code with your phone to access information about the vaccine(s) to be given.

SIGN HERE

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

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

Location:
LA RA

Administered by: _____

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

Texas Immunization Registry (ImmTrac2)

Adult Consent Form

First Name _____ Middle Name _____ Last Name _____

Date of Birth (mm/dd/yyyy) ____/____/____ Gender: ☐ 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). The Texas Immunization Registry is a secure and confidential service that consolidates and stores your immunization records. With your consent, your 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 and 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 the Texas Immunization Registry. Once in the Texas Immunization Registry, my immunization information may by law be accessed by: a Texas physician, or other health-care provider legally authorized to administer vaccines, for treatment of the individual as a patient; a Texas school in which the individual is enrolled; a Texas public health district or local health department, for public health purposes within their areas of jurisdiction; a state agency having legal custody of the individual; a payor, currently authorized by the Texas Department of Insurance to operate in Texas for immunization records relating to the specific individual covered under the payor's policy. 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 appropriate box to indicate whether you are a First Responder or an Immediate Family Member.

☐ **I am a FIRST RESPONDER.** ☐ **I am an IMMEDIATE FAMILY MEMBER (older than 18 years of age) 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. 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)

PROVIDERS REGISTERED WITH the Texas Immunization Registry: Please enter client information in the Texas Immunization Registry and affirm that consent has been granted. **DO NOT** fax to the Texas Immunization Registry. **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

Texas Department of State Health Services
Immunizations

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