

Patient's Name: _____ Today's Date: ___/___/___
 Patient's Birth Date: ___/___/___ Patient's Age: _____ Gender: (M / F) Phone: _____
 Address: _____ City / Zip: _____

REQUIRED INSURANCE INFORMATION

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 #: _____

*** If you are filing insurance, please include a copy of your card with this consent form**

TRICARE Military Member's Information:	Policy Holder Name: _____	DOB: ___/___/___	SS#: _____	DOD #: _____
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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 ever felt dizzy or faint before, during or after receiving a shot? Yes___ No___
5. Has the patient or an immediate family member had a seizure; has the patient had brain or other nervous system problems? Yes___ No___
**IF yes, describe _____
6. Does the patient have cancer, leukemia, HIV/AIDS, or any other immune system problem? Yes___ No___
**IF yes, describe _____
7. Does the patient have a parent or sibling with an immune system problem? Yes___ No___
**IF yes, describe _____
8. In the past 6 months, has the patient taken medications that affect the immune system such as cortisone, prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments? Yes___ No___
If yes list medication and date of last treatment _____
9. Has the patient received transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug in the past year? Yes___ No___
**IF yes, describe _____
10. Does the patient have a blood or bleeding disorder such as thrombocytopenia or thrombocytopenia purpura? Yes___ No___
11. (If 20 years or younger) Is the patient on aspirin therapy? Yes___ No___
12. Is the patient pregnant or could become pregnant in the next month? Yes___ No___
13. Has the patient received a vaccination in the past 4 weeks? Yes___ No___
**IF yes, please list vaccine(s) _____

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, via QR code, 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/ school 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.



 **Parent/Gaurdian signature:** _____ **Date:** ___/___/___

PCHD Staff signature: _____ **Date:** ___/___/___



Texas Immunization Registry (ImmTrac2) Minor Consent Form



A parent, legal guardian or managing conservator must sign this form if the client is younger than 18 years of age.

Child's First Name, Middle Name, Last Name, Date of Birth, Gender, Telephone, Email address

Child's Address, City, State, Zip Code, County, Apartment # / Building #

Mother's First Name, Mother's Maiden Name

Race (select all that apply)

Ethnicity (select only one)

- Checkboxes for American Indian or Alaska Native, Asian, Black or African-American, Hispanic or Latino, Recipient Refusal, Native Hawaiian or Other Pacific Islander, White, Other Race, Not Hispanic or Latino

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 child's (younger than 18 years of age) immunization records.

Consent for Registration of Child and Release of Immunization Records to Authorized Persons/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 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.

Please mark the following box to indicate whether your child is an Immediate Family Member of 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 child's information in the Texas Immunization Registry.

Parent, legal guardian, or managing conservator:

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.

Contact Information: Questions? Tel: (800) 348-9158 • Fax: (512) 776-7790 • www.ImmTrac.com Texas Department of State Health Services • Immunizations Texas Immunization Registry – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

Scan this QR code, with your phone, to access information regarding the vaccine(s) being given.



Texas Vaccines for Children (TVFC) Program Patient Eligibility Screening Record

A record of all children 18 years of age or younger who receive immunizations through the Texas Vaccines for Children (TVFC) Program must be kept in the health care provider's office for a minimum of five (5) years.

1. Child's Name: Last Name, First Name, MI
2. Child's Date of Birth: MM DD YYYY
3. Parent, Guardian, or Individual of Record: Last Name, First Name, MI

- 4. Please check the category that applies: [] is enrolled in Medicaid, [] is an American Indian or an Alaskan Native, [] Does not have health Insurance, [] is enrolled in the Children's Health Insurance Plan CHIP, [] is underinsured: 1. has commercial insurance, but coverage does not include vaccines, 2. commercial insurance covers only select vaccines, [] Has private insurance that covers vaccines

