Parker County Hospital District

www.parkercountyhd.org
(vaccine information available on the Event Calendar page)

1130 Pecan Street
Weatherford, Texas 76086
(817) 458-3254

Clinic Location: _____ **Clinic Date:** _____

Patient Name: _____ **Gender: (M / F)** **Birth Date:** _____

Address: _____ **City/ State /Zip:** _____ **Phone:** _____

REQUIRED INSURANCE INFORMATON

****If the patient is 18 or under and not insured, please fill out the highlighted TVFC section on the back of this form****
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 ☐ Medicare ☐ Private **BCBS** ☐ **CIGNA** ☐ **Humana** ☐ **Medicaid** ☐ Amerigroup ☐ Cook Children's **Tricare** ☐ **United** ☐

Card Holder Name:	Member ID (All letters & numbers):
Card Holder DOB:	Group #:

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

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 or an immediate family member had a seizure; has the patient had brain or other nervous system problems? Yes____ No____
   **IF yes, describe_____

5. Does the patient have cancer, leukemia, HIV/AIDS, or any other immune system problem? Yes____ No____
   **IF yes, describe_____

6. In the past 1-3 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 _____

7. 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_____

8. Is the patient pregnant or could become pregnant in the next month? Yes____ No____

9. 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 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/ school aware of any changes prior to being vaccinated.

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

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

Texas Department of State Health Services
IMMUNIZATION REGISTRY (ImmTrac)
CONSENT FORM
(Please type or print clearly.)

ImmTrac
Texas Immunization Registry

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

Mother's First Name / La Madre Nombre

Mother's Maiden Name / Nombre de Soltera de la Madre

ImmTrac, the Texas immunization registry, is a free service of the Texas Department of State Health Services (DSHS). 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 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 state's central immunization registry ("ImmTrac"). Once in ImmTrac, the child's immunization information may by law be accessed by:

- a public health district or local health department, for public health purposes within their areas of jurisdiction;
- a physician, or other health-care provider legally authorized to administer vaccines, for treating the child as a patient;
- a state agency having legal custody of the child;
- a Texas school or child-care facility in which the child is enrolled;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child.

I understand that I may withdraw this 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, ImmTrac Group – MC 1946, P.O. Box 149347, Austin, Texas 78714-9347.

ImmTrac, el registro de inmunización de Texas, es un servicio gratis que proporciona el Departamento Estatal de Servicios de Salud de Texas (DSHS). El registro de inmunización es un servicio seguro y confidencial que consolida y guarda el récord de inmunizaciones de su niño(a) (menor de 18 años de edad). Con su consentimiento, la información de la inmunización de su niño(a) será incluida en ImmTrac. Los doctores, departamentos de salud pública, escuelas y otros profesionales autorizados pueden tener acceso al historial de inmunización de su niño(a) para asegurar que las vacunas importantes no le falten.

El Departamento Estatal de Servicios de Salud le anima a participar voluntariamente en el registro de inmunización de Texas.

Consentimiento Para Registrar al Menor y Dar a Conocer los Documentos de Inmunización a las Entidades Autorizadas

Entiendo que, con mi consentimiento a continuación, autorizo que se dé a conocer la información de inmunización del menor al DSHS, y además entiendo que el DSHS incluirá esta información en el registro central de inmunización del estado ("ImmTrac"). Una vez que la información del menor esté en ImmTrac, por ley la puede acceder:

- el distrito de salud pública o el departamento de salud local, para propósitos de salud pública dentro de sus áreas de jurisdicción;
- el médico, o algún otro médico o proveedor de atención de salud legalmente autorizado para administrar vacunas, en el tratamiento del menor como paciente;
- la agencia estatal que tenga la custodia legal del menor;
- la escuela o la guardería de Texas en que el menor esté inscrito;
- el pagador, actualmente autorizado por el Departamento del Seguro de Texas para operar en Texas, con respecto a la cobertura del menor.

Entiendo que puedo retirar este consentimiento para incluir información sobre el menor en el Registro de ImmTrac y mi consentimiento para dar a conocer la información del registro en cualquier momento mediante comunicación escrita a Texas Department of State Health Services, ImmTrac Group – MC 1946, P.O. Box 149347, Austin, Texas 78714-9347.

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

Revised 5/18/12

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

A screening record of all children 18 years of age or younger who receive immunizations through the TVFC Program must be kept in the health-care provider's office. The record may be completed by the parent, gaurdian, or individual of record or by the healthcare provider. TVFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure eligibility status for the program. While varification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines under the TVFC Program.

Date of Screening: _____
mm/dd/yyyy

Child's Name: _____
Last Name First Name MI

Child's Date of Birth: _____ Age: _____
mm/dd/yyyy

Parent/Guardian/Individual of Record: _____
Last Name First Name MI

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

(a) ☐ Is enrolled in Medicaid, or

Medicaid Number: _____ Date of Eligibility (mm/dd/yyyy) _____

(b) ☐ Is an American Indian or an Alaskan Native, or

(c) ☐ Does not have health insurance (uninsured), or

(d) ☐ Is a patient who receives benefits from the Children's Health Insurance Plan (CHIP) and is being seen at a facility that bills CHIP, or

CHIP Number: _____ Date of Eligibility (mm/dd/yyyy) _____

(e) ☐ 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.

(f) ☐ Has private insurance that covers vaccines