Parker County Hospital District

1121 Pecan Street
Weatherford, Texas 76086
817-341-2520

Clinic Location:_________________________ Clinic Date:_____________________

Patient Name:_________________________ Birth Date:_________________________

Address:_________________________ City/ State/ zip_________________________

Please answer the following questions about the child receiving the immunizations today:

1. Is the child sick today? ____Yes ____No
2. Does the child have allergies to medications, food, or any vaccine? _____Yes _____No
3. Has the child had a serious reaction to a vaccine in the past? _____Yes ____No
4. Has the child had a health problem with asthma, lung disease, heart disease, kidney disease, metabolic disease (diabetes), or a blood disorder? ____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. Has the child had a seizure, brain, or other nervous system problem? ____Yes ____No
7. Does the child have cancer, leukemia, AIDS, or any other immune system problem? ____Yes ___No
8. Has the child taken cortisone, prednisone, other steroids, or anticancer drugs or had radiation treatment in the past 3 months? ____Yes ____No
9. Has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug in the past year? _____Yes _____No
10. Is the child/ teen pregnant or is there a chance she could become pregnant during the next month? _____Yes _____No
11. Has the child received vaccinations in the past 4 weeks? ____Yes ____No

Did you bring your child's immunization record with you today? ____Yes ____No

Consent for Immunization of a Minor: I, (parent)________________ give permission and consent for (child) ______________________DOB ___/___/_____ to receive the appropriate immunizations needed.

Sign Here →

Signature:____ **Date:** ____/____/____

Staff Signature:_____________________________________ **Date:** ____/____/____

IMMUNIZATION REGISTRY (ImmTrac)
CONSENT FORM

ImmTrac
Texas Immunization Registry

REGISTRO DE INMUNIZACIÓN (ImmTrac)
Formulario de CONSENTIMIENTO

(Please type or print clearly.)

(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*

ImmTrac, the Texas immunization registry, is a free service of the Texas Department of State Health Services. 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 consent below, I register my child in the Texas Department of State Health Services immunization registry and authorize the registry to include my child's information in the registry and to release past, present, and future immunization records on my child to a parent of the child and any of the following:

- public health district or local health department;
- physician or health care provider;
- insurance company, health maintenance organization or payor;
- school or child care facility in which the child is enrolled and/or
- state agency having legal custody of the child.

I understand that I may withdraw the 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, Immunization Registry, 1100 West 49th Street, Austin, Texas 78756.

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**

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.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

Notificación Sobre Privacidad: Tan solo por unas cuantas excepciones, usted tiene el derecho de solicitar y de ser informado sobre la información que el Estado de Texas reúne sobre usted. A usted se le debe conceder el derecho de recibir y revisar la información al requerirla. Usted también tiene el derecho de pedir que la agencia estatal corrija cualquier información que se ha determinado sea incorrecta.
Diríjase a http://www.dshs.state.tx.us para más información sobre la Notificación sobre privacidad.
(Referencia: Government Code, sección 552.021, 552.023, 559.003 y 559.004)

Questions? (800) 252-9152 • (512) 458-7284 • www.ImmTrac.com
Texas Department of State Health Services • ImmTrac Group – MC 1946 • P.O. Box 149347 • Austin, TX 78714-9347

Stock No. C-7
Revised 07/22/08

TEXAS VACCINE FOR CHILDREN PROGRAM – PATIENT ELIGIBILITY SCREENING RECORD

Purpose: To determine eligibility and the source of funds for the Texas Department of Health to be reimbursed for vaccines.

A record must be kept in the office of the health care provider that reflects the status of all children 18 years of age or younger, who receive immunizations through the Texas Vaccines for Children Program. The record may be completed by the parent, guardian, or individual of record, or by the health care provider. This same record may be used for all subsequent visits as long as the child's eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines.

The above named child qualifies for vaccines through the Texas Vaccines for Children Program because he/she (check 1st category that applies, check only one)

- ☐ (a) enrolled in Medicaid or
- ☐ (b) does not have health insurance or
- ☐ (c) is an American Indian or
- ☐ (d) is an Alaskan Native or
- ☐ (e) is underinsured (has health insurance that Does Not pay for vaccines) & routinely referred to a facility that is not a Federally Qualified Health Rural Health Clinic for immunizations or
- ☐ (f) is a patient who is served by any type of public health clinic and does not meet any of the above criteria or
- ☐ (g) is a patient who receives benefits from the Children's Health Insurance Plan (CHIP).
- ☐ (h) has private insurance, or is paying for services.

Signature:______________________________ Date:______________________________

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.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

Texas Department of State Health Services
Immunization Branch

Stock No. C-10
Revised 02/09