Health Heroes Texas

Vaccine Information Sheets can be found at www.dshs.texas.gov/

Meningitis ☐ HPV ☐

(817)366-8595
(817)597-6514

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 ☐ Private ☐ Medicaid **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 HHTX to administer required vaccinations to myself/child. I release Health Heroes Texas, 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 will make HHTX/ school aware of any changes prior to being vaccinated. I authorize HHTX to provide my child's school with documentation of vaccinations given today.

Patient/Parent signature:____________ **Date:**____/____/________

HHTX Staff signature:____________ **Date:**____/ ____/________

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

IMMUNIZATION REGISTRY (ImmTrac2) Minor Consent Form

(Please print clearly)

Child's Last Name ______________________ Child's Middle Name ______________________

Child's First Name Child's ______________________ Child's Gender: Male ☐ Female ☐

___/___/______
Date of Birth *Children younger than 18 years old only

Child's Address ______________________ Apartment # ________ Telephone (____)________

City ____________ State ______ Zip Code ________ County ____________

Mother's First Name ______________________ Mother's Maiden Name ______________________

ImmTrac2, 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 (younger than 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac2.

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 ("ImmTrac2"). Once in ImmTrac2, 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 ImmTrac2 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.

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:

Date ______________ Printed Name ______________________

Signature ______________________

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects aboutyou. 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) Stock No. C-7 Revised 09/2017

Texas Vaccines for Children 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. The record may be completed by the parent, guardian, individual of record, or by the health care provider. TVFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure eligibility status for the program. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines under the TVFC Program.

1. Child's Name: ______________ (Last Name) ______________ (First Name) ____ (MI)
2. Child's Date of Birth: ___/___/______
3. Parent, Guardian, or Individual of Record: ______________ (Last Name) ______________ (First Name) ____ (MI)
4. Primary Provider's Name: ______________ (Last Name) ______________ (First Name) ____ (MI)
5. Please check the category that applies

( ) Is enrolled in Medicaid ____________Medicaid Number ____________Date of Eligibility

( ) Is an American Indian or an Alaskan Native

( ) Does not have health insurance

( ) The patient 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 selected vaccine

( ) Has private insurance that covers vaccines