



ImmTrac Athena

Clinic Location: _____ Clinic Date: _____
Patient Name: _____ Gender: (M / F) Birth Date: _____
Address: _____ City/State /Zip: _____ Phone: _____

REQUIRED INSURANCE INFORMATION

****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 BCBS CIGNA Humana Medicaid Amerigroup
 Medicaid 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) globulin 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 will make PCHD/ school aware of any changes prior to being vaccinated. I authorize PCHD to provide my child's school with documentation of vaccinations given today.

Patient/Parent signature: _____ Date: ___/___/___
PCHD Staff signature: _____ Date: ___/___/___



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 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) 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