

TARRANT COUNTY PUBLIC HEALTH
Consent for Immunization

Payment Type:
 Cash _____ Check# _____
 Invoice Amount: _____

COMPLETE THE SHADED AREAS

Child's Information (Please Print)

Last Name:		First Name:		Middle Name:	
Street Address:		Apt #	City:	County:	State: Zip Code:
Date of Birth: ____/____/____ (Month/Day/Year)		Sex: M F	Race:	Age:	Phone Number ()

Name of Parent/Guardian

Last Name:		First Name:		Maiden Name:	
Date of Birth: ____/____/____ (Month/Day/Year)		Sex: M F	Race	Relationship to Child:	

Eligibility

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**):

- No Insurance*
- Enrolled in Medicaid, Medicaid Number: # _____ (TCPH will bill Medicaid for services)
- Enrolled in the Children's Health Insurance Plan (CHIP). CHIP Number: # _____ (TCPH will bill CHIP for services)
- Underinsured (Not insured for immunizations)*
- American Indian or Alaskan Native
- Private Insurance: (Not VFC eligible-will not receive VFC vaccines at school)

***Knowingly falsifying information on this document constitutes fraud. By signing this form, I hereby attest that the above information is true and correct. I declare that the person named above is an authorized person and is eligible to receive TVFC vaccines.**

Consent for Registration and Authorization for Electronic Exchange and Release of Immunization Information

I understand that, by granting the consent, I am authorizing the release of the child's immunization information to: (**Please initial boxes**)

- ➔ Tarrant County Immunization Registry (TCIR),
- ➔ ImmTrac2-the Texas immunization registry, a free service of the Texas Department of State Health Services (DSHS)

Once in the registry, 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.

By signing this form I wish to INCLUDE my child's information in the above selected registries. I understand that I may withdraw this consent at any time.

Screening Checklist for Today's Immunizations

For parents and guardians: Please answer these questions by circling the correct answer.				
1. Is the child sick today?	Yes	No		
2. Does the child have allergies to medications, eggs, food, a vaccine component, or latex?	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 lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	Yes	No		
5. Has the child had a seizure; has the child had brain or other nervous system problems. Has the child ever had Guillain-Barré syndrome?	Yes	No		
6. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	Yes	No		
7. In the past 3 months, has the child taken medications that weaken their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?	Yes	No		
8. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	Yes	No		
9. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	Yes	No		
10. Has the child received vaccinations in the past 4 weeks?	Yes	No		
Date of chickenpox illness: ➔ _____ (month and year) or Date of chickenpox immunization: ➔ _____				

VACCINATION CONSENT: I received a copy of the Vaccine Information Statement for each vaccine. I know the risks of the disease each vaccine prevents. I know the benefits and risks of each vaccine. I have had a chance to ask questions about the diseases, the vaccines, and how the vaccines are given. I am an adult who can legally consent for the person named above to get vaccines. I freely and voluntarily give my signed permissions for these vaccines.

Signature: _____		Date: _____		Signature _____		Date _____		Date VIS Given
Parent, Guardian or Managing Conservator				School Nurse				
Vaccine to be given	Date given	Series	Mfg.	Lot #	VIS Date	Site	Given By	

