City of Amarillo Department of Public Health 1000 Martin Rd Amarillo, TX 79107

Immunization Registration

Patient Name: _____ Age: _____

CONSENT

By signing below, you acknowledge that you have received or were offered a copy of the HIPAA privacy notice and Vaccine Information Statement (VIS) 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 disease, the vaccines, and how the vaccines are given. I know that the person receiving the vaccine will have the vaccine put into his/her body to prevent the infectious disease. I am an adult who can legally consent for the person named above to get the vaccine. I freely and voluntarily give my signed permission for the vaccines.

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

ELIGIBILITY

- ☐ Medicaid # _____
  Date Eligible _____
- ☐ No Health Insurance
- ☐ American Indian
- ☐ Native American
- ☐ Underinsured
  - has commercial (private) health insurance, but coverage does not include vaccines
  - insurance covers only selected vaccines (TVFC-eligible for non-covered vaccines only)
  - Insurance caps vaccine coverage at a certain amount. Once that coverage amount is reached: eligible
- ☐ CHIP #_____
  Group # _____
  Date Eligible _____

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, guardian, 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 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.

SCREENING

1. Is Patient sick today?	Yes	No
2. Does Patient have allergies to medications, food, vaccine or latex?	Yes	No
3. Has Patient had a serious reaction to a vaccine?	Yes	No
4. Does/Has Patient have health problems like Diabetes, Asthma, Lung, heart or kidney disease, blood disorders, Cancer, AIDS, any other major health problems or on long term aspirin therapy?	Yes	No
5. If the Patient to be vaccinated is between the ages of 2 and 4 years, has a health care provider told you that the child had wheezing or asthma in the past 12 months?	Yes	No
6. Has Patient had a seizure or a brain disorder?	Yes	No
7. Has Patient taken cortisone, prednisone, or other steroids or anti-cancer drugs or had radiation treatments in the past 3months?	Yes	No
8. Has Patient received a transfusion of blood or blood products or been given immune (gamma) globulin in the past year?	Yes	No
9. Is the Patient pregnant or is there a chance she could become pregnant during the next month?	Yes	No
10. Has the Patient had vaccines/shots in last 4 weeks?	Yes	No
11. Has the Patient had Chickenpox, if so when? Mth/ Yr _____	Yes	No

List any allergies: _____

SIGNATURES

Patient/Legal Representative: _____ Date: _____

If Legal Representative, relationship to Patient: _____

Clinic Downtime Form

Date Vaccine & VIS Given	Vaccine Given	Mfg	Lot #	Site Used	VIS Date

Administrator's Signature _____

***Notes**_____ **eCW id:** _____

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
IMMUNIZATION REGISTRY (ImmTrac)
ADULT CONSENT FORM

ImmTrac
Texas Immunization Registry

(Please print clearly)

Last Name

First Name

Middle Name

For Clinic/Office Use

Date of Birth

Gender: ☐ **Male** ☐ **Female**

Address

Apartment #

Telephone

City

State

Zip Code

County

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 immunization records for public health purposes (e.g., giving all doctors treating a patient a central place to see that patient's immunization records). With your consent, your immunization information will be included in ImmTrac. *For a family member younger than 18 years of age, a parent, legal guardian or managing conservator may grant consent for participation for that minor by completing the ImmTrac Minor Consent Form (#C-7). The ImmTrac Minor Consent Form (#C-7) can be downloaded by visiting www.ImmTrac.com.*

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

Consent for Registration and Release of Immunization Records to Authorized Persons/Entities

I understand that, by granting the consent below, I am authorizing release of my 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, my immunization information may by law be accessed by:

- a Texas physician, or other health care provider legally authorized to administer vaccines, for treatment of the individual as a patient;
- a Texas school in which the individual is enrolled;
- a Texas public health district or local health department, for public health purposes within their areas of jurisdiction;
- a state agency having legal custody of the individual;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas for immunization records relating to the specific individual covered under the payor's policy.

I understand that I may withdraw this consent at any time.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my information in the Texas immunization registry.

Individual (or individual's legally authorized representative): _____
Printed Name

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

Upon completion, please fax or mail form to the DSHS ImmTrac Group or a registered Health-care provider.

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com
Texas Department of State Health Services • ImmTrac Group – MC 1946 • P.O. Box 149347 • Austin, TX 78714-9347

Stock No. EF11-13366
Revised 05/18/12

TEXAS Department of State Health Services

***PROVIDERS REGISTERED WITH ImmTrac** – Please enter client information in ImmTrac and affirm that consent has been granted. DO NOT fax to ImmTrac. Retain this form in your client's record.*