



Registration Form

PATIENT INFORMATION

Event DATE: _____ SOCIAL SECURITY #: _____

Name: LAST: _____ FIRST: _____ MI: _____

Date of Birth: _____ Gender: Male Female

Address: _____ City: _____ State: _____ Zip Code _____

Cell Phone: _____ Alternate Phone: _____

PARENT/LEGAL GUARDIAN INFORMATION:

Name: LAST: _____ FIRST: _____ MI: _____ Date of Birth: _____

Cell Phone: _____ Alternative Phone: _____ SOCIAL SECURITY #: _____

Relationship to Patient: Parent Spouse OTHER: _____

E-Mail Address: _____

PRIMARY INSURANCE INFORMATION:

Name of Primary Insurance: _____ Telephone #: _____

Subscriber Name: LAST: _____ FIRST: _____ MI: _____

Subscriber Date of Birth: _____ Subscriber SOCIAL SECURITY #: _____

Relationship to Patient: Parent Legal Guardian OTHER: _____

Policy ID/Member #: _____ Group #: _____ Co-payment: _____

Claim Address: _____ City: _____ State: _____ Zip Code: _____

PLEASE CHECK WHICH VACCINES YOU CONSENT STUDENT TO RECEIVE:

MIDDLE SCHOOL	
<input type="checkbox"/> Meningococcal (MCV) (Required)	<input type="checkbox"/> Tdap (Required)
<input type="checkbox"/> HPV (Cancer Prevention/Recommended)	<input type="checkbox"/> Flu (Recommended)
HIGH SCHOOL	
<input type="checkbox"/> Meningococcal (MCV) (Required)	<input type="checkbox"/> Flu (Recommended)
<input type="checkbox"/> HPV (Cancer Prevention/Recommended)	<input type="checkbox"/> Meningococcal B (Recommended by most colleges/universities)

Date: _____
 Name of Patient: _____
 DOB: _____ Age: _____
 MRN: _____ VN: _____



**University
Health**

Vaccination Consent Form

TO THE PATIENT: You have the right to be informed about 1) your condition, 2) the recommended medical care, and 3) the risks related to this vaccine. This disclosure is designed to provide you this information, so that you can decide whether to consent to receive this vaccine. Please ask your vaccination administrator any remaining questions you have before signing this form.

Gender: Female Male

Vaccine Name:

- | | |
|---|--|
| <input type="checkbox"/> Chickenpox/Varicella | <input type="checkbox"/> Meningococcal type B (Trumenba®) |
| <input type="checkbox"/> Covid (1st dose) | <input type="checkbox"/> Measles, Mumps, Rubella, Varicella (MMRV) |
| <input type="checkbox"/> Covid (2nd dose) | <input type="checkbox"/> Measles, Mumps, Rubella (MMR) |
| <input type="checkbox"/> Covid (3rd dose) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Diphtheria, Tetanus, Pertussis (DTaP) | <input type="checkbox"/> Pediarix® (DTaP-HepB-IPV) |
| <input type="checkbox"/> Haemophilus Influenza Type B Conjugate (Hib) | <input type="checkbox"/> Pentacel® (DTaP-Hib-IPV) |
| <input type="checkbox"/> Hepatitis A (Hep A) | <input type="checkbox"/> Pneumococcal Conjugate/PCV13/Prevnar® |
| <input type="checkbox"/> Hepatitis B (Hep B) | <input type="checkbox"/> Pneumococcal Polysaccharide/PPSV/Pneumovax® |
| <input type="checkbox"/> Hepatitis B Immunoglobulin (IG) | <input type="checkbox"/> Polio (IPV) |
| <input type="checkbox"/> Human papillomavirus (HPV9) | <input type="checkbox"/> Rabies |
| <input type="checkbox"/> Influenza (inactivated) | <input type="checkbox"/> Rotavirus |
| <input type="checkbox"/> Kinrix® (DTaP-IPV) | <input type="checkbox"/> Shingles/Zoster |
| <input type="checkbox"/> Quadracel® (DTaP-IPV) | <input type="checkbox"/> Tetanus, Diphtheria, Pertussis (Tdap) |
| <input type="checkbox"/> Meningococcal (MCV4) | <input type="checkbox"/> Tetanus, Diphtheria (Td) |
| <input type="checkbox"/> Meningococcal type B (Bexsero®) | |

The Screening Questionnaire was completed: Yes No

CONSENT STATEMENT:

- I agree that the person named above will get the vaccines indicated and that this person will have a vaccine put into his or her body to prevent infectious diseases.
- I received or was offered a copy of the Vaccine Information Statement for these vaccines.
- I know the risks and the benefits of the vaccine.
- I have had a chance to ask questions about the vaccine 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 permission for this vaccine.
- I give my consent to have this vaccine recorded in the City-wide and State-wide online vaccine databases and that this record can be given to other health care providers, schools, or places that provide child care.

Signature of Patient/Parent/Guardian: _____ Date: _____

Relationship to Patient: _____

Signature/Title of Vaccine Administrator/EID#: _____ Date: _____

Witness Signature: _____ Date: _____

Was an interpreter used? Yes No

Was the consent obtained by telephone? Yes No

Did the patient give verbal consent while being unable to physically sign? Yes No

If applicable, Name and ID# of Interpreter: _____ Language: _____



Patient Name: _____
 Date of Birth: _____ Age: _____
 MRN: _____
 VN: _____



Pediatric Screening Questionnaire

1. Is the child sick today? Yes No
 If yes explain: _____
2. Does the child have allergies to medications, food or vaccines? Yes No
 If yes – to what and what happens: _____
3. Has the child ever had a serious reaction to vaccines in the past? Yes No
 If yes to what and what happened: _____
4. Does the child have a long-term health problem (ex. Asthma, diabetes, bleeding disorder, seizure or other nervous system disorder)?
 Yes No
 If yes- explain: _____
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
 If yes-explain: _____
6. Does the child have cancer, leukemia, AIDs or other autoimmune disorder or is on medication like a cortisone, prednisone, anticancer meds or has X-ray treatments? Yes No
 If yes, explain: _____
7. Has the child received a blood transfusion or blood products or immune globulin in the past year? Yes No
 If yes explain: _____
8. Has the child received vaccines in the past 4 weeks? Yes No
 If yes – what vaccine: _____
9. Is the child pregnant? Yes No
 LMP: _____
10. Has the child ever had the chicken pox disease? Yes No
 If so, what year? _____ (if the child has had the chicken pox disease they will **NOT** need the varicella immunization)
11. What is your preferred pharmacy? _____

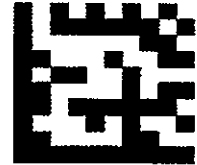




TEXAS
Health and Human
Services

Texas Department of State
Health Services

IMMUNIZATION REGISTRY (ImmTrac2)
Minor Consent Form



(Please print clearly)

Child's Last Name

Child's Last Name

Child's First Name

Child's First Name

Child's Middle Name

Child's Middle Name

Child's Date of Birth

Child's Date of Birth

*Children younger than 18 years old only.

Child's Gender: Male Female

Child's Address

Child's Address

Apartment #

Apartment #

Telephone

Telephone

City

City

State

State

Zip Code

Zip Code

County

County

Mother's First Name

Mother's First Name

Mother's Maiden 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:

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.texas.gov> for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

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

PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in ImmTrac2 and affirm that consent has been granted. **DO NOT** fax to ImmTrac2. Retain this form in your client's record.