Waco-McLennan County Public Health District
225 W. Waco Drive
Waco, TX 76707
IMMUNIZATION FORM

DATE OF SERVICE: ____________________

First Name/Primer Nombre	**Middle Int.**/Nombre Segundo	**Last Name**/Apellido

SEX (Check one) ☐ Male Hombre ☐ Female Mujer	**DATE OF BIRTH** Fecha de Nacimiento ____/____/____ **Month** Mes **Day** Dia **Year** Año	**ADDRESS:** ______ Dirección **CITY/COUNTY:** ______ ZIP ______ Codigo/Condado **TELEPHONE #:** ______ Teléfono	**Household receives W.I.C.:** **Recibe W.I.C. en su casa:** ☐ Yes / Si ☐ No / No

MEDICAID NUMBER/Numero de Medicaid	SS NUMBER / Numero del Seguro Social	MOTHER'S MAIDEN NAME/Apellido de Soltera de la Madre

FOR OFFICE USE ONLY

BILLING CODES: Admin. Procedure code 90471 for 1st Immunization Administered, 90472 for each additional Immunization Administered

Circle Series of Immunization		Manufacturer	Vaccine Procedure Code		Lot#	Site
1 2 3	Pediarix (DTaP/IPV/Hep B)	GSK	90723			
1 2 3 4	Pentacel (DTaP/HIB/IPV)	Sanofi Pasteur	90698			
1 2 3 4	Kinrix (DTap/IPV)	GSK	90696			
1 2 3 4 5	DTaP (acellular)	Sanofi Pasteur LED GSK	90700			
1 2 3 4	TD (adult)	Sanofi Pasteur LED WYT	90714			
1	TdaP	Sanofi Pasteur GSK	90715			
1 2 3 4	IPV	Sanofi Pasteur	90713			
1 2 4	HIBcv	Sanofi Pasteur LED	90648	90645		
1 2 3	HEP B (Pedi)	MER GSK	90744			
1 2 3	HEP B (Adult)	MER GSK	90746			
1 2 3	HIB-HEP B	MER	90748			
1 2	HEP A (Pedi)	GSK MER	90633			
1 2	HEP A (Adult)	GSK MER	90632			
1 2 3 4	HEP B/HEPA (TwinRix)	GSK	90636			
1 2	MMR / MMRV	MER	MMR 90707	MMRV 90710		
1 2 3	HPV	MER	90649			
1 2 3	ROTA TEQ	MER	90680			
1 2	Influenza (6-35 mo)	Sanofi Pasteur	Medicaid Code 90749	90657		
1 2	Influenza (>3 yrs.- Adult)	Sanofi Pasteur	Medicaid Code 90749	90658		
1 2	Influenza -flu mist >2yrs.-Adult	Sanofi Pasteur	90660			
1	Pneum. Poly.	MER	90732			
1 2 3 4	Pneumococcal Conjugate	Wyeth-Ayerst Lab	90670			
1 2	Varicella	MER	90716			
1	Zoster (Shingles)	MER	90736			
1 2	Meningococcal	Sanofi Pasteur	Menomune 90733	Menactra 90734		
1 2 3	Typhoid	Sanofi Pasteur	90691			
1 2	Yellow Fever	Sanofi Pasteur	90717			
1	Immune Globulin		90281			
TB Skin Test Given	Yes No	Sanofi Pasteur	86580			

- **The client or the client's parental guardian must answer ALL of the following questions before any immunizations will be given.**
- El cliente or el custodio legal tiene que contestar TODAS las preguntas siguientes antes de recibir inmunizaciónes.

(Circle Answer/Marca con círculo a la repuesta)

Yes/Sí No 1. Is the client sick today or has he/she been sick in the last week?
Está el cliente enfermo hoy o él/ella estado enfermo en la ultima semana?

Yes/Sí No 2. Is the client taking any medications? If so, please list them here:____________________
Toma el cliente alguna medicina? Sí responde sí, por favor los lista aqui:____________________

Yes/Sí No 3. Does the client have allergies to gelatin/Jello, neomycin, streptomycin, polymyxin B, baker's yeast, eggs, thimerosol, latex or reaction to Immune Globulin?
Tiene el cliente alergias a la gelatina, los huevos, neomicina, estretomicina, polymyxin B o thimerosol, productos que tienen levadura depanadero, productos de latex o la reacción a Globulin Inmune?

Yes/Sí No 4. Has the client had a serious reaction to a vaccine in the past?
El cliente ha tenido alguna reacción grave a una vacuna en el pasado?

Yes/Sí No 5. Has the client had a seizure or other nervous system disorder?
Ha tiendo el cliente un ataque o otro desorden nervioso de sistema?

Yes/Sí No 6. Does the client (or other persons in the home) have cancer, leukemia, AIDS or any other immune system problem?
El cliente o personas que vivan en la misma casa, hay alguien que tenga el SIDA, cancer, leukemia o un sistema inmunológico débil?

Yes/Sí No 7. Has the client taken cortisone or other steroids, anticancer drugs, or x-ray treatments in the past 3 months?
Ha tenido el cliente cortisone o otro steriods, las drogas de anticancer, o los tratamientos de radiografía en los pasado tres (3) meses?

Yes/Sí No 8. Has the client received a transfusion of blood, plasma, or been given a medicine called immune (gamma) globulin in the past 12 months?
Ha recibido el cliente un transfusion de sangre, el plasma o fue dado una medicina llamado globin inmune(gamma) en los pasados doce (12) meses?

Yes/Sí No 9. Has the client had the chickenpox illness? Vaccine?
Ha tenido el cliente la enfermedad de Viruela o Varicela?

Yes/Sí No 10. Has the client had a TB skin test in the past 3 days?
Ha tenido el cliente una prueba de piel de TB en los pasados tres (3) dias?

Yes/Sí No 11. FOR TB SKIN TEST: Has the client had a Positive TB test in the past or taken TB medications? If so, when?____________________
Prueba de TB(Tuberculosis): ¿Ha tenido el cliente una prueba positiva de TB en el pasado o la medicina tomada de TB? ¿Cuando?____________________

Yes/Sí No 12. Has the client had an immunization in the past 4 weeks?
Ha tenido el cliente una inmunización en los pasados cuatro (4) semenas?

Yes/Sí No 13. FOR FEMALES: Is the client pregnant or could she become pregnant in the next (1) month?
Note: A client must NOT become pregnant within 1 month after receiving the MMR (measles, mumps, rubella) vaccine or the Varicella (Chickenpox) vaccine.
Si el cliente es una Mujer- ¿El cliente está embarazada o podriá llegar a ser embarazada en un (1) mes?
Nota: Un cliente no debe llegar a ser embarazada dentro de un (1) mes después de recibir la vacuna de MMR (Sarampión, Paperas, Rubéola) ni la vacuna de Varicela.

Yes/Si No 14. Do you have a chronic medical condition yourself (regardless of your age). Such as:
Asthma or another lung disease? **YES/NO** Heart disease? **YES/NO** Diabetes? **YES/NO** Kidney disease **YES/NO** Blood disease? **YES/NO** Are you pregnant? **YES/NO** Have you been vaccinated with Pneumonia Vaccine **YES/NO**
*** Tiene usted alguna condicion medica cronica (sin importer sue dad). Tal como:
Asma o alguna otra enfermedad pulmonar? **SI/NO** Enfermedad del Corazon? **SI/NO** Enfermedad de los riñones **SI/NO** Enfermedad de la sangre? **SI/NO** Esta usted embarazada? **SI/NO** Tiene usted un sistema inmuno deficiented/comprometedor? **SI/NO**

Yes/Si No 15. Does the client have a family physician? If "**NO**" see provider list.
Tiene el cliente un doctor familiar? En caso que "**NO**" vea la lista de proveedores.

**The client or the client's parent/ guardian must answer ALL questions on the back of this form before any immunizations will be given.
**El cliente or el custodio legal tiene que contestar TODAS las preguntas que están detrás de esta hoja antes de recibir inmunizaciónes.

CONSENT FOR IMMUNIZATIONS: I have received, read or had explained to me the vaccine information statement and I understand this information. I give permission to the Waco-McLennan County Public Health District, its staff and other health care personnel under its sponsorship, to give immunizations and/or TB skin test to the person identified on this form. I understand that immunizations given at school sites may be given without my being present.

CONSENTIMIENTO PARA INMUNIZACIÓNES: Ha recibido, leído/o explicado la información y si entiendo esta información. Le doy permiso al personal de esta institución para que se le administren vacunas o la prueba de Tuberculosis a la persona nombrada en esta forma. Entiendo que las vacunas administradas en la escuela se podrán dar sin que yo este presente.

Signature of CONSENTING ADULT: ____________________ **Date Signed**__________
Firma del adulto que da permiso: (Check one/marca uno) ☐ Parent/ padre/madre ☐ Guardian/El guardián ☐ Other/Otro Fecha de Firmar
VIS form/s given & vaccine ADMINISTERED BY: ____________________ **Date Signed**__________

Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by the Waco-McLennan County Public Health District for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the Waco-McLennan County Public Health District.

I understand that diagnosis or treatment of me by the Waco-McLennan County Public Health District may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. The Waco-McLennan County Public Health District is not required to agree with the restrictions that I may request. However, if the Waco-McLennan County Public Health District agrees to a restriction that I request, the restriction is binding on the Waco-McLennan County Public Health District.

I have the right to revoke this consent, in writing, at any time, except to the extent that the Waco-McLennan County Public Health District has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by the Waco-McLennan County Public Health District staff, another health care provider or a health plan. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review the Waco-McLennan County Public Health District's Notice of Privacy Practices prior to signing this document.

I have received a copy of the Waco-McLennan County Public Health District's Notice of Privacy Practices.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Waco-McLennan County Public Health District.

The Notice of Privacy Practices for the Waco-McLennan County Public Health District is also posted in each department of the Health District and on the City of Waco's web site at www.waco-texas.com /services/health.

This Notice of Privacy Practices also describes my rights and the duties of the Waco-McLennan County Public Health District with respect to my protected health information.

The Waco-McLennan County Public Health District reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised Notice of Privacy Practices by accessing the Waco-McLennan County Public Health District's web site, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next visit.

____ ____________________

Signature of Client or Authorized Representative   Relationship

____ ____________________

Name of Client   Date Of Birth   Date