TEXAS Health and Human Services | Texas Department of State Health Services

School Located Vaccine Consent for Adolescents

Section 1: Eligibility

Eligibility for immunizations through the Texas Vaccines for Children (TVFC) Program must take place with each immunization visit to ensure eligibility status for the program.

To determine if a child (0-18 years of age) is eligible to receive federal vaccine through the TVFC Program, date and mark the appropriate eligibility category. If column A-D is marked, the child is eligible for the TVFC vaccine provided at this event. **If column E-G is marked** the child is not eligible for TVFC vaccine provided at this event, **STOP HERE** and see your private health care provider for vaccinations.

Date	Eligible for VFC Vaccine				State Eligible		Not Eligible
	A	B	C	D	E	F	G
	Medicaid Enrolled ID# Eligibility Date:	No Health Insurance	American Indian or Alaskan Native	*Underinsured	For Private Providers only- Not applicable at this event.	**CHIP enrolled	Has health insurance that covers vaccines.

**Underinsured includes children with health insurance that does not include vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance.*

***Children enrolled in the State of Texas Children's Health Insurance Program (CHIP), must get vaccines through their CHIP Provider. A $10 administrative fee may be requested.*

Section 2: Information about Student to Receive Vaccine (please print)

Student's Name: (Last)	(First)	(M.I.)	**Student's Date of Birth** month_____ day_____ year_____		
Parent/Legal Guardian Name: (Last)	(First)	(M.I.)	**Student's Age**	**Student's Gender:** M☐ F☐	**Hispanic:** Yes ☐ No ☐
Address			**Race: White** ☐ **Black** ☐ **Asia** ☐ **Alaskan** ☐ **American Indian** ☐ **Pacific Islander** ☐ **Other**___		
City	**State**	**Zip**	**Parent/Legal Guardian Phone Number:**		
Parent Email	**Appointment Notification Preference:** ☐ **EMAIL** ☐ **Phone Call** ☐ **TEXT**		**Immtrac2:**		
Student's Doctor (Last, First):			**Doctor Phone Number:**		
School Name	**Homeroom Teacher**		**Grade**		

Section 3: Screening for Vaccine Eligibility

The following questions will help us to know if the student can get the recommended grade applicable vaccinations. If you answer "NO" to all the following questions, the student can probably get the vaccines. If you answer "YES" to one or more the following questions, the student may be able to get the vaccinations, but we will contact you to discuss your options. Please mark **YES** or **NO** for each question.

(Please continue to the back to complete Consent Form)

Student's Name:_____ **Student's DOB:**_____

	YES	NO
1. Has the student been moderately or severely ill in the week prior to the vaccine clinic and has not improved?	☐	☐
2. Does the student have **any** serious **allergies**? Please list: _____	☐	☐
3. Has your child ever had a serious reaction to a previous dose of any vaccine?	☐	☐
4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a vaccine?	☐	☐
5. Has your child had brain or other nervous system problems?	☐	☐
6. If female; is the student pregnant or a chance they could become pregnant in the within the next month? *Date of Last Menstrual Period: _____	☐	☐

Section 4: Consent

CONSENT FOR STUDENT'S VACCINATION:

I have read or had explained to me the most recent Vaccine Information Statement for: Tdap (tetanus, diphtheria, and acellular pertussis), HPV (Human Papillomavirus), Influenza, MenACWY/ MCV 4 (Meningococcal Conjugate), Men B (Meningococcal Group B), or other vaccine listed and understand the risks and benefits of vaccination. I acknowledge that I have received a copy of the Texas Department of State Health Services Notice of Privacy Practices.

☐ I **GIVE CONSENT** to the Texas Department of State Health Services and its staff for the student named on this form to be vaccinated with the following vaccines:

The legally authorized person must initial next to each vaccine that they want the patient to receive and sign and date the form below. (If this consent is not signed, the patient did not receive the vaccine).

Tdap _____ HPV* _____ Influenza _____

MCV4 _____ Men B_____ Other_____ (name of other vaccine _____)

Signature of Legally Authorized Person:_____ **Date:** _____

(Must be a handwritten signature)

Relationship to Patient_____

FOR OFFICE USE ONLY:

Section 5: Nursing Immunization Documentation

*****ASSESS LMP***(if applicable)** _____

Date	Vaccine	Mfg	Lot No	Site Given	Given by	Date VIS Given	VIS Date
	Tdap						
	HPV *						
	Influenza						
	MCV4						
	Men B						
	Other						

Nurse Signature:_____

Signature above indicates immunization given according most current SDO's

Date: _____

Interpreter: _____

DSHS Field Office Stamp:

Not Valid Unless Signed, Stamped & Dated

DATE	CLINICAL NOTES: