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

Texas Immunization Registry (ImmTrac2)

Minor Consent Form

A parent, legal guardian or managing conservator must sign this form if the client is younger than 18 years of age.

Child's First Name _____ Child's Middle Name _____ Child's Last Name _____

Child's Date of Birth (mm/dd/yyyy) _____/_____/_____ Child's Gender: ☐ Male ☐ Female

Telephone _____ - _____ - _____ Email address _____

Child's Address _____ Apartment # / Building # _____

City _____ State _____ Zip Code _____ County _____

Mother's First Name _____ Mother's Maiden Name _____

Race (select all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race
☐ Recipient Refused

Ethnicity (select only one)

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Other

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). The Texas 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 the Texas Immunization Registry. Doctors, public health departments, schools, and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed. For more information, see Texas Health and Safety Code Sec. 161.007 (d). *https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.007*.

Consent for Registration of Child and Release of Immunization Records to Authorized Persons/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 Texas Immunization Registry. Once in the Texas Immunization 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; and 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 at any time by submitting a completed Withdrawal of Consent Form in writing to the Texas Department of State Health Services, Texas Immunization Registry.

State law permits the inclusion of immunization records for First Responders and their immediate family members in the Texas Immunization Registry. A "First Responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency. An "immediate family member" is defined as a parent, spouse, child, or sibling who resides in the same household as the First Responder. For more information, see Texas Health and Safety Code Sec. 161.00705. *https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.00705*.

Please mark the box below to indicate whether your child is an Immediate Family Member of a First Responder.

☐ **I am an IMMEDIATE FAMILY MEMBER of a First Responder.**

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 _____ Signature _____ Date _____

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)

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

Questions? Tel: (800) 252-9152 • Fax: (512) 776-7790 • *https://www.dshs.texas.gov/immunize/immtrac/*
Texas Department of State Health Services • Immunizations • Texas Immunization Registry – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

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

Texas Vaccines for Children (TVFC) Program

Patient Eligibility Screening Record

A record of all children 18 years of age or younger who receive immunizations through the Texas Vaccines for Children (TVFC) Program must be kept in the health care provider's office for a minimum of five (5) years. The record may be completed by the parent, guardian, individual of record, or by the health care 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.

1. Child's Name: _____
   Last Name First Name MI
2. Child's Date of Birth: ____/____/____
   MM DD YYYY
3. Parent, Guardian, or Individual of Record: _____
   Last Name First Name MI
4. Primary Provider's Name: _____
   Last Name First Name MI
5. To determine if a child (0 through 18 years of age) is eligible to receive federal vaccine through the TVFC Program, at each immunization encounter or visit, enter the date and mark the appropriate eligibility category. If Column A - F is marked, the child is eligible for the TVFC Program. If column G is marked the child is not eligible for federal VFC vaccine.

Date	Eligible for VFC Vaccine				State Eligible		Not Eligible
	A	B	C	D	E	F	G
	Medicaid Enrolled	No Health Insurance	American Indian or Alaskan Native	* Underinsured served by FQHC, RHC, or deputized provider	** Other underinsured	*** Enrolled in CHIP	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. In addition, to receive VFC vaccine, underinsured children must be vaccinated through a Federally Qualified Health Center (FQHC), a Rural Health Clinic (RHC), or under an approved deputized provider. The deputized provider must have a written agreement with an FQHC or an RHC and the state, local, or territorial immunization program in order to vaccinate underinsured children.*

*** Other underinsured are children that are underinsured but are not eligible to receive federal vaccine through the TVFC Program because the provider or facility is not an FQHC or an RHC, or a deputized provider. However, these children may be served if vaccines are provided by the state program to cover these non-TVFC-eligible children.*

**** Children enrolled in the State of Texas Children's Health Insurance Program (CHIP). An agreement between the DSHS Immunization Unit and CHIP stipulates that vaccines for eligible CHIP enrollees are purchased through the federal contract.*

Texas Vaccines for Children (TVFC) Program

Patient Eligibility Screening Record

(Continued)

Date	Eligible for VFC Vaccine				State Eligible		Not Eligible
	A	B	C	D	E	F	G
	Medicaid Enrolled	No Health Insurance	American Indian or Alaskan Native	* Underinsured served by FQHC, RHC, or deputized provider	** Other underinsured	*** Enrolled in CHIP	Has health insurance that covers vaccines
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Medicaid:

Medicaid Number: ____________________

Date of Eligibility: ____________________

CHIP:

CHIP Number: ____________________

Group Number: ____________________

Date of Eligibility: ____________________

Private Insurance:

Name of Insurer: ____________________

Insurance Name: ____________________

Insurer Contact Number: ____________________

Policy or Subscriber Number: ____________________

Texas A&M School of Nursing
Nursing Mobile CARE
(979) 436-0587
TXANMobileCARE@tamu.edu

TEXAS A&M UNIVERSITY
School of Nursing

8447 Riverside Parkway
MS - 1359 TAMU
Bryan, TX 77807

Immunization Consent Form

Patient Name:_____ **Date of Birth:** _____

Parents – for more information of VACCINE GRADE LEVEL REQUIRMENTS - please click the link below:

https://www.dshs.texas.gov/sites/default/files/immunize/school/pdf/6-14-2022-2023-MinReq_K-12.pdf

I give consent to administer the following CHECKED vaccines:

	VACCINE	SCHEDULE	VACCINE INFORMATION STATEMENT	
			ENGLISH	SPANISH
	Meningococcal ACYW	1 dose - age 11-12 years, Booster at age 16 years	VIS_English_MCV4	VIS_Spanish_MCV4
	DTaP	5 dose series at age 2, 4, 6, 15-18 months, 4-6 years	VIS_English_DTaP	VIS_Spanish_DTaP
	DTaP, IPV/Polio	5 dose series - age 4-6 years	VIS_English_Multi	VIS_Spanish_Multi
	IPV/Polio	4 doses age 2 months, 4 months, 6-18 months, and 4-6 years	VIS_English_IPV/Polio	VIS_Spanish_IPV/Polio
	TDaP	1 Dose age 11-12 years Booster every 10 years (or 5 years in certain cases i.e. dirty wound or burn)	VIS_English_TDaP	VIS_Spanish_TDaP
	Td	Booster every 10 years (or 5 years in certain cases i.e. dirty wound or burn)	VIS_English_Td	VIS_Spanish_Td
	MMRV	1st Dose Received at age 12-15 Months 2nd Dose at age 4-6 Years	VIS_English_MMRV	VIS_Spanish_MMRV
	MMR	1st Dose at age 12-15 months 2nd Dose at age 4-6 years	VIS_English_MMR	VIS_Spanish_MMR
	Varicella	1st Dose at age 12-15 months 2nd Dose at age 4-6 years	VIS_English_Varicella	VIS_Spanish_Varicella
	Fluzone	1 dose per year – age 6 Months or Older	VIS_English_Flu	VIS_Spanish_Flu
	Flublok	1 dose per year – age 18 Years or Older		
	Fluzone (High Dose)	1 dose per year – age 65 Years or Older		
	HPV	1 dose between the ages of 9-26 years	VIS_English_HPV	VIS_Spanish_HPV
	Hepatitis A	1 dose after age 1 year, 2nd dose 6 months later	VIS_English_HepA	VIS_Spanish_HepA
	OTHER			

I do not consent for the following vaccines: _____

_____ _____

Signature of Patient or Parent/Guardian **Date**

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MS - 1359 TAMU
Bryan, TX 77807

For parents/guardians – these questions will help us determine which vaccines your child may be given today. If you answer yes to any questions, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked.

Please answer the following:	**YES**	**NO**	**UNSURE**
Is the patient sick today?			
Does the patient have a fever?			
Does the patient have allergies to medications, food, latex, eggs or egg products? List allergy:			
Has the patient had a serious reaction to a vaccine in the past?			
Does the patient have a long-term health problem with lung, heart kidney or metabolic disease (e.g. diabetes), a blood disorder, no spleen, cochlear implant, or spinal fluid leak? If YES please specify:			
Does the patient have a history of Guillain-Bare Syndrome (a rare, paralytic disorder)?			
If the patient is 2-4 years of age, has a healthcare provider told you that the child has wheezing or asthma in the last 12 months?			
Has the patient, a sibling, or a parent had a seizure; Has the patient had brain or other nervous system problems?			
Does the patient have cancer, leukemia, AIDS, or any other immune system problem? If YES please specify:			
Does the patient have a parent or sibling with an immune system problem?			
In the past 3 months, has the patient taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for treatment for rheumatoid arthritis, Crohn's disease, or psoriasis; radiation treatment?			
Has the patient received a transfusion of blood or blood products, or been given an antiviral drug or medicine called immune (gamma) globulin in the past year?			
For Children: Does the patient have (or had) a disease of the stomach or intestines?			
For Women: Is the patient pregnant or is there a chance she could become pregnant in the next 4 weeks?			
Has the patient received vaccinations in the past 4 weeks? Name of vaccine?			

Signature of Patient or Parent/Guardian **Date**