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

IMMUNIZATION REGISTRY (ImmTrac2)
Minor Consent Form

(Please print clearly)

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

Child's Date of Birth (mm/dd/yyyy) _____/_____/_____ *Children younger than 18 years old only

Child's Gender: ☐ Female ☐ Male

Telephone _____ - _____ - _____

Child's Address _____ Apartment # _____ Email address _____

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
☐ Recipient Refused

The Texas Immunization Registry (ImmTrac2) 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 _____ X _____ 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 • ImmTrac2 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.**

Stock No. C-7

Revised 02/2021

Vaccine Documentation Form

(800)252-9152

I received or was offered a copy of the 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 an infectious disease. I am an adult who can legally consent for the person named below to get the vaccine. I freely and voluntarily give my signed permission for the vaccines.

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

Privacy Notice: I acknowledge that I have received a copy of my immunization provider's HIPAA Privacy Notice.

☐ Yes, HIPAA received ☐ No HIPAA received

Recibí o se me ofreció una hoja con información sobre cada vacuna (VIS). Conozco los riesgos de las enfermedades que cada vacuna previene. Conozco los beneficios y riesgos que estas vacunas tienen. He tenido la oportunidad de hacer preguntas sobre las enfermedades, las vacunas y cómo son administradas las vacunas. Sé que la persona recibiendo la vacuna la tendrá en su cuerpo para prevenir una enfermedad contagiosa. Soy adulto y puedo dar permiso legalmente para que le den la vacuna a la persona nombrada abajo. Por mi propia voluntad firmo y doy permiso para que le den esta vacuna.

Notificación Sobre Privacidad: Tan solo por unas cuantas excepciones, usted tiene el derecho de solicitar y de ser informado sobre la información que el Estado de Texas reúne sobre usted. A usted se le debe conceder el derecho de recibir y revisar la información al requerirla. Usted también tiene el derecho de pedir que la agencia estatal corrija cualquier información que se ha determinado sea incorrecta. Diríjase a http://www.dshs.tx.gov para más información sobre la Notificación sobre privacidad. (Referencia: Government Code, Sección 552.021, 552.023, 559.003 y 559.004)

Aviso sobre derechos de la vida privada: Yo admito haber recibido una copia del aviso sobre derechos de la vida privada.

☐ Si, Recibí HIPAA ☐ No Recibí HIPAA

Hepatitis B	DTaP/DT/DTP/Td/Tdap	*Haemophilus influenzae* type b(Hib)	Pneumococcal Conjugate (PCV)	Polio (IPV/OPV) (Circle one)	Rotavirus (RV)	Measles, Mumps, and Rubella (MMR)	Measles	Varicella (Chickenpox)	Meningococcal (MCV4/MPSV4)	Hepatitis A	Human Papillomavirus (HPV)	Pneumococcal Polysaccharide (PPSV)	Serogroup B Meningococcal (MenB)	Influenza	Date / Fecha	Signature/~~Relation/Address/Telephone~~ / Firma/~~Relación/Dirección/Teléfono~~
																X
Witness Signature/Firma del Testigo																
Witness Signature/Firma del Testigo																
Witness Signature/Firma del Testigo																
Witness Signature/Firma del Testigo																
Witness Signature/Firma del Testigo																

Check vaccines to be given then enter date, sign, and complete the section below.

Señale las vacunas que se van a dar, escriba la fecha, firme y llene la parte de abajo.

ProCare Health Services
2101 E. Griffin Pkwy
Mission TX 78572
(956) 205-2204

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

Immunization Unit

Stock No. C-100
Rev. 04/2017

Date	Vaccine	Mfg.	Lot No.	Site Given	Given by	Date VIS Given	VIS Date
	Hepatitis B						
	Hepatitis B						
	Hepatitis B						
	DTaP/DT/DTP/Td/Tdap						
	DTaP/DT/DTP/Td/Tdap						
	DTaP/DT/DTP/Td/Tdap						
	DTaP/DT/DTP/Td/Tdap						
	DTaP/DT/DTP/Td/Tdap						
	DTaP/DT/DTP/Td/Tdap (Circle one)						
	Hib						
	Hib						
	Hib						
	Hib						
	PCV						
	PCV						
	PCV						
	PCV						
	IPV/OPV						
	IPV/OPV						
	IPV/OPV						
	IPV/OPV (Circle one)						
	RV						
	RV						
	RV						
	MMR						
	MMR						
	Measles						
	Varicella (Chickenpox)						
	Varicella (Chickenpox)						
	Varicella History/Date of Varicella Disease						
	MCV4/MPSV4						
	MCV4/MPSV4 (Circle one)						
	Hepatitis A						
	Hepatitis A						
	HPV						
	HPV						
	HPV						
	PPSV						
	MenB						
	MenB						
	Influenza						

Last/Apellido First/Nombre Middle/Segundo nombre Birth date/Fecha de nacimiento Sex/Sexo

Address/Dirección ( ) Telephone Number/Número de teléfono Race/Raza

City/Ciudad State/Estado Zip/Código postal County/Condado

[redacted] Medicaid Number/Número de Medicaid WIC Number/Número de WIC

Parent's Name/Nombre del padre o de la madre Mother's Maiden Name/Apellido de soltera de la madre

Vaccine Administration Record for Minor

Patient Name: _____

Birthdate: _____/_____/_____

Before administering any vaccines, give the patient copies of all pertinent Vaccine Information Statements (VIS) and make sure he/she understands the risks and benefits of the vaccine(s). Always provide or update the patient's personal record card.

Vaccines	Date given	Funding Source	Site	Vaccine		Vaccine Information Statement (VIS)		Vaccinator (initials)
				Lot #	Mfr.	Date on VIS	Date given	
Hep B		P	L / R					
		P	L / R					
		P	L / R					
Dtap/Dt/ DTP/ Td/Tdap		P	L / R					
		P	L / R					
		P	L / R					
		P	L / R					
		P	L / R					
		P	L / R					
Hib		P	L / R					
		P	L / R					
		P	L / R					
		P	L / R					
PCV 13		P	L / R					
		P	L / R					
		P	L / R					
		P	L / R					
IPV		P	L / R					
		P	L / R					
		P	L / R					
		P	L / R					
RV		P	L / R					
		P	L / R					
		P	L / R					
MMR		P	L / R					
		P	L / R					
Varicella		P	L / R					
		P	L / R					
MCV4		P	L / R					
		P	L / R					
Hep A		P	L / R					
		P	L / R					
HPV 9 (Gardasil)		P	L / R					
		P	L / R					
		P	L / R					
MenB (Bexsero)		P	L / R					
		P	L / R					
Influenza		P	L / R					
		P	L / R					
		P	L / R					

I received a copy of THE VIS, read and know about the benefits and risks for each vaccine. I voluntarily give permission for vaccines; and, with my signature I consent to all vaccines administered. (One time signature)

ProCare Health Services
2101 E. Griffin Pkwy. Mission, TX 78572 • Ph:(956) 285-2204 Fx:(956) 285-2222

Name / Nombre: _____

Signature / Firma: X _____