

MMH FAMILY HEALTH CLINIC

509 N Maple * PO Box 370 * Muenster TX 76252
(940) 759-2226

Date: _____

I, _____, have read or have had explained to me the information about pneumonia/influenza and the pneumococcal/influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the pneumococcal/influenza vaccine and ask that the vaccine be given to me or the person named above who I am authorized to make this request.

Patient name if minor: _____

Signature – relation to patient

Date

Age _____ DOB _____ Zip code _____

Medicare # _____

Medicaid # _____

Self Pay CASH CHECK # _____ Total collected \$ _____

(Make Checks Payable to MMH)

Patient received: Influenza vaccine Pneumonia vaccine (circle which was given)
VIS 08/06/2021 VIS 05/12/2023

PATIENT INFORMATION

PATIENT NAME _____
(LAST) (FIRST) (MIDDLE) (MAIDEN)

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

MAILING ADDRESS: _____
(ADDRESS) (CITY) (STATE) (ZIP) (COUNTY)

MARITAL STATUS: M S D W COMMON LAW SEX: M F RACE: CAUCASIAN BLACK HISPANIC ASIAN INDIAN

HOME PHONE: _____ CELL: _____ WORK: _____
(AREA+PHONE NUMBER)

EMPLOYER/COMPANY: _____ OCCUPATION: _____

WORK ADDRESS _____

FILL OUT BELOW IF PATIENT IS A MINOR

PARENT NAME: _____
(LAST) (FIRST) (MIDDLE) (MAIDEN)

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

MAILING ADDRESS IF DIFFERENT FROM ABOVE: _____
(ADDRESS) (CITY) (STATE) (ZIP) (COUNTY)

*****PLEASE SIGN BELOW SO WE CAN FILE YOUR INSURANCE*****

****PLEASE PROVIDE US WITH A COPY, FRONT AND BACK, OF YOUR INSURANCE CARD.****

ASSIGNMENT OF BENEFITS: I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO MMH FAMILY HEALTH CLINIC FOR SERVICES RENDERED. SIGNATURE: _____ DATE _____

RELEASE OF INFORMATION: I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY FOR THE PROCESSING OF ANY CLAIMS. SIGNATURE: _____ DATE: _____

*****IF INSURANCE IS UNDER OTHER SUBSCRIBER WE NEED THEIR INFORMATION. *****

SUBSCRIBER NAME: _____ DOB: _____

ADDRESS IF DIFFERENT FROM ABOVE: _____

IF YOUR INSURANCE DOES NOT PAY YOU WILL BE RESPONSIBLE FOR PAYMENT.



Texas Department of State
Health Services

Texas Immunization Registry (ImmTrac2) Adult Consent Form



First Name _____ Middle Name _____ Last Name _____
Date of Birth (mm/dd/yyyy) _____ Gender: ☐ Male ☐ Female Telephone _____ Email address _____

Address _____ Apartment # / Building # _____

City _____ State _____ Zip Code _____ County _____

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

Race (select all that apply)			Ethnicity (select only one)
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African-American	<input type="checkbox"/> Hispanic or Latino
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Other Race	<input type="checkbox"/> Not Hispanic or Latino
<input type="checkbox"/> Recipient Refused			<input type="checkbox"/> 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 immunization records. With your consent, your 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 and Release of Immunization Records to Authorized Persons / Entities

I understand that, by granting the consent below, I am authorizing release of my 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, my immunization information may by law be accessed by: a Texas physician, or other health-care provider legally authorized to administer vaccines, for treatment of the individual as a patient; a Texas school in which the individual is enrolled; a Texas public health district or local health department, for public health purposes within their areas of jurisdiction; a state agency having legal custody of the individual; a payor, currently authorized by the Texas Department of Insurance to operate in Texas for immunization records relating to the specific individual covered under the payor's policy. 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 appropriate box to indicate whether you are a **First Responder** or an **Immediate Family Member**.

☐ I am a **FIRST RESPONDER**. ☐ I am an **IMMEDIATE FAMILY MEMBER** (older than 18 years of age) of a First Responder.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my information in the Texas Immunization Registry.
Individual (or individual's legally authorized representative):

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/immutracs/>

Texas Department of State Health Services • Immunizations • Texas Immunization Registry – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

Influenza (Flu) Vaccine (Inactivated or Recombinant): *What you need to know*

Many vaccine information statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1. Why get vaccinated?

Influenza vaccine can prevent **influenza (flu)**.

Flu is a contagious disease that spreads around the United States every year, usually between October and May. Anyone can get the flu, but it is more dangerous for some people. Infants and young children, people 65 years and older, pregnant people, and people with certain health conditions or a weakened immune system are at greatest risk of flu complications.

Pneumonia, bronchitis, sinus infections, and ear infections are examples of flu-related complications. If you have a medical condition, such as heart disease, cancer, or diabetes, flu can make it worse.

Flu can cause fever and chills, sore throat, muscle aches, fatigue, cough, headache, and runny or stuffy nose. Some people may have vomiting and diarrhea, though this is more common in children than adults.

In an average year, **thousands of people in the United States die from flu**, and many more are hospitalized. Flu vaccine prevents millions of illnesses and flu-related visits to the doctor each year.

2. Influenza vaccines

CDC recommends everyone 6 months and older get vaccinated every flu season. **Children 6 months through 8 years of age** may need 2 doses during a single flu season. **Everyone else** needs only 1 dose each flu season.

It takes about 2 weeks for protection to develop after vaccination.

There are many flu viruses, and they are always changing. Each year a new flu vaccine is made to protect against the influenza viruses believed to be likely to cause disease in the upcoming flu season.

Even when the vaccine doesn't exactly match these viruses, it may still provide some protection.

Influenza vaccine **does not cause flu**.

Influenza vaccine may be given at the same time as other vaccines.

3. Talk with your health care provider

Tell your vaccination provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of influenza vaccine**, or has any **severe, life-threatening allergies**
- Has ever had **Guillain-Barré Syndrome** (also called "GBS")

In some cases, your health care provider may decide to postpone influenza vaccination until a future visit.

Influenza vaccine can be administered at any time during pregnancy. People who are or will be pregnant during influenza season should receive inactivated influenza vaccine.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting influenza vaccine.

Your health care provider can give you more information.



U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4. Risks of a vaccine reaction

- Soreness, redness, and swelling where the shot is given, fever, muscle aches, and headache can happen after influenza vaccination.
- There may be a very small increased risk of Guillain-Barré Syndrome (GBS) after inactivated influenza vaccine (the flu shot).

Young children who get the flu shot along with pneumococcal vaccine (PCV13) and/or DTaP vaccine at the same time might be slightly more likely to have a seizure caused by fever. Tell your health care provider if a child who is getting flu vaccine has ever had a seizure.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5. What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at www.vaers.hhs.gov or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff members do not give medical advice.*

6. The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Claims regarding alleged injury or death due to vaccination have a time limit for filing, which may be as short as two years. Visit the VICP website at www.hrsa.gov/vaccinecompensation or call **1-800-338-2382** to learn about the program and about filing a claim.

7. How can I learn more?

- Ask your health care provider.
- Call your local or state health department.
- Visit the website of the Food and Drug Administration (FDA) for vaccine package inserts and additional information at www.fda.gov/vaccines-blood-biologics/vaccines.
- Contact the Centers for Disease Control and Prevention (CDC):
 - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
 - Visit CDC's website at www.cdc.gov/flu.

