2024-25 CHILD FLU CONSENT

DEFENDING YOU AGAINST THE FLU

Parker County Hospital District Outreach

1115 Pecan Drive Weatherford, TX 76086
(817) 458-3254 www.pchdtx.gov

PATIENT INFORMATION

FULL NAME:

DATE OF BIRTH: / / AGE: GENDER: MALE FEMALE

ADDRESS:

CITY: ZIP CODE:

CELL PHONE NUMBER:

PARENT / GUARDIAN INFORMATION:

FULL NAME:

SCHOOL CLINIC INFORMATION (PROVIDE IF APPLICABLE):

NAME OF SCHOOL: GRADE: TEACHER'S NAME:

REQUIRED INSURANCE INFORMATION (PLEASE CHECK THE BOX THAT APPLIES):

By completing the following insurance section, I authorize payment of medical benefits for any services provided. This information will be used for the purpose of evaluating and administering claims of benefits.

☐ AETNA ☐ BLUE CROSS ☐ CIGNA ☐ HUMANA ☐ UNITED

Subscriber (Policy Holder) Name: Subscriber (Policy Holder) DOB: / /

MEMBER ID (POLICY) NUMBER: GROUP NUMBER:

☐ TRICARE (MILITARY INSURANCE):

Subscriber (Policy Holder) Name: Subscriber (Policy Holder) DOB: / /

Subscriber SS# NUMBER: Subscriber DOD NUMBER:

VACCINATION AND HEALTH QUESTIONS:

☐	1. Is the person to be vaccinated feeling sick today?	YES	NO
☐	2. Has the patient ever had a severe or life threatening allergic reaction to the flu vaccine?	YES	NO
☐	3. Does the patient have an allergy to any components of the flu vaccine?	YES	NO
☐	4. Has the patient ever been diagnosed with Guillain-Barre Syndrome?	YES	NO
☐	5. Has the patient ever felt dizzy or faint before, during or after a shot?	YES	NO

Authorization for the Administration of the Influenza Vaccine

I am providing this consent form to Parker County Hospital District in order that my child may be given the influenza vaccination. I have read and understand the information I have received concerning the possible benefits and side effects of the influenza vaccination. I hereby acknowledge that based on the information presented to me, my child is eligible to receive the influenza vaccination on this date. My child is feeling well today and has not recently had a fever. I understand that no assurance can be given that the influenza vaccination will give my child immunity from contracting ANY strain of influenza. I hereby acknowledge that I have received access to a copy of the Vaccine Information Sheet, via the provided QR code, on the 2024-2025 Influenza Vaccine. I release Parker County Hospital District, its employees representatives and agents from any liability for giving my child the influenza vaccination. I accept responsibility for seeking medical attention for any problems associated with my child receiving the vaccine. I have had the opportunity to have all my questions answered. I understand that this consent is valid for 6 months and I will make PCHD/the school aware of any changes prior to my child being vaccinate. I authorize PCHD to provide my child's school with documentation of vaccinations given today.

SIGN HERE

Signature of Parent/Gaurdian Date

For detailed information about the flu vaccine, scan this QR code with your phone

PCHD Staff Signature Date

Clinic Location: _____

Date: __/____/____

Vaccine Lot #: _____

Expiration Date: _____

Location: LA RA

Administered by: _____

The Back of this Form MUST Be Completed

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 Refusal

Ethnicity (select only one)

☐ Hispanic or Latino ☐ Other
☐ Not Hispanic or Latino

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 following box 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)

Contact Information: Questions? Tel: (800) 348-9158 • Fax: (512) 776-7790 • **www.ImmTrac.com**
Texas Department of State Health Services • Immunizations
Texas Immunization Registry – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

Texas Department of State Health Services
Immunizations
Stock No. C-7
Revised 02/2022

Scan this QR code, with your phone, to access information regarding the vaccine(s) being given.

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. **Please check the catagory that applies:**
   - ☐ **is enrolled in Medicaid** _____ **Medicaid Number** _____/_____/_____ **Date of Eligibility**
   - ☐ **is an American Indian or an Alaskan Native**
   - ☐ **Does not have health Insurance**
   - ☐ **is enrolled in the Children's Health Insurance Plan CHIP**
   - ☐ **is underinsured:**
     1. **has commercial insurance, but coverage does not include vaccines**
     2. **commercial insurance covers only select vaccines**
   - ☐ **Has private insurance that covers vaccines**