



Vaccine Consent Form for TVFC

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.

Table with 8 columns: Date, Eligible for TVFC Vaccine (A-D), State Eligible (E-G), and Not Eligible (G). Rows include categories like Medicaid Enrolled, No Health Insurance, American Indian or Alaskan Native, *Underinsured, For Private Providers only, **CHIP enrolled, and 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 Patient (Pt.) to Receive Vaccine (please print)

Form for patient information including fields for Patient's Name, Parent/Legal Guardian Name, Address, City, State, Zip, Pt. Date of Birth, Pt. Age, Pt. Gender, Pt. Hispanic, Race, and Appointment Notification Preference.

Section 3: Screening for Vaccine Eligibility

The following questions will help us to know if the patient can get their recommended vaccinations. If you answer "YES" to one or more of the following questions, additional questions may be asked by the nursing team.

Table with 3 columns: Question, Yes, No. Contains 8 screening questions regarding patient health, allergies, reactions, chronic conditions, and vaccination history.

(Please continue to the back to complete Vaccine Consent Form)

Patient's Name: _____ DOB: _____

Section 3: Screening for Vaccine Eligibility Continued

	Yes	No
9. In the past 3 months, has the patient taken medications that weaken their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or any radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>
10. In the past year, has the patient received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral?	<input type="checkbox"/>	<input type="checkbox"/>
11. Is the patient pregnant or is there a chance she could become pregnant during the next month? *Date of Last Menstrual Period, if applicable: _____	<input type="checkbox"/>	<input type="checkbox"/>
12. Has the patient received vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>

Section 4: Consent

CONSENT FOR PATIENT'S VACCINATION:

I have read or had explained to me the most recent Vaccine Information Statement for the vaccinations I initialed below 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 patient named on this form to be vaccinated with the following vaccines:

Legally authorized person must initial by each vaccine they wish the patient to receive.

Tdap/DTaP _____ Hep. B _____ Hib _____ PCV13 _____ Influenza _____
 Polio _____ Rotavirus _____ MMR* _____ Varicella* _____ MCV4 _____
 Hep A _____ HPV* _____ Men B _____ Other _____ PPSV23 _____

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

(Must be a handwritten signature)

Relationship to Patient: _____

FOR OFFICE USE ONLY:

Section 5: Nursing Immunization Documentation

*****ACCESS LMP*** (if applicable)**

Date	Vaccine	Mfg.	Lot No	Site Given	Given by	Date VIS Given	VIS Date
	Hepatitis B						10/15/21
	DTaP/DT/Td/Tdap						8/6/21
	Hib						8/6/21
	PCV13						2/4/22
	IPV						8/6/21
	RV						10/15/21
	MMR *						8/6/21
	Varicella *						8/6/21
	MCV4						8/6/21
	Other						
	Hepatitis A						10/15/21
	HPV *						8/6/21
	PPSV23						10/30/19
	Influenza						8/6/21
	Men B						8/6/21

DSHS Field Office Stamp:

Nurse Signature: _____ **Date:** _____

(Signature above indicates immunization given according most current SDO's)

Interpreter: _____

DSHS Gainesville
 1714 Justice Center Blvd., Suite A
 Gainesville, TX 76240
 940-665-9315 Opt. 5

Not Valid Unless Signed, Stamped & Dated

DATE	CLINICAL NOTES: