MINOR PATIENT INFORMATION & CONSENT

Passport Health/Staying Healthy Medical Services 4700 Dexter Dr #300 Plano TX 75093

1 Yes/ No Is your child sick today or had fever in the past 48 hours?
2 Yes/ No Is your child allergic to any food, medication or a vaccine component. List any_____
3 Yes/ No Does your child have/had health problems with lung, heart, kidney or metabolic disease or on long term aspirin therapy?
4 Yes/ No If the child is between 2 and 4, has a health care provider told you the child had wheezing or asthma in the last 12 mos?
5 Yes/ No Has your child, a sibling or a parent had a seizure. Has the child had a brain or other nervous system disorder?
6 Yes/ No Does your child have cancer, leukemia, AIDS or any other immune system problem?
7 Yes/ No In the past 3 mos, has your child taken cortisone, prednisone, or other steroids or anti-cancer drugs or had radiation treatments?
8 Yes/ No In the past yr, has your child received a transfusion of blood or blood products or been given immune(gamma) globulin or an antiviral drug?
9 Yes/ No Is your child/teen pregnant or had vaccines/shots in the last 4 weeks or had chickenpox, if so, when? _____
Other Notes_____

Initials **Patient or Guardian must initial by each vaccine prior to receiving it.**

_____**DTAP: (6wks-7yrs)** (Tetanus, diphtheria and pertussis): I am not allergic to aluminum phosphate, formaldehyde, glutaraldehyde, 2-phenoxyethanol or a prior DTaP vaccine and have not had encephalopathy, or progressive neurological disorder. **VIS pub**: **8/6/2021**

_____**HPV(Gardasil 9):** I have not had a reaction to a prior dose or any vaccine components, am not pregnant, do not have acute febrile illness or a weakened immune system.. **VIS pub: 8/6/2021**

_____**Haemophilus Influenzae Type B (HIB):** I was not allergic to HIB, am not less than 6 wks old and am not moderately or severely ill. **VIS pub: 8/6/2021**

_____**Hepatitis A:** I am not allergic to aluminum hydroxide, sodium borate and /or sodium chloride. **VIS pub: 01/31/25**

_____**Hepatitis B:** I am not hypersensitive to yeast, formaldehyde, aluminum hydroxide or thimerosal. **VIS given: 01/31/25**

_____**Meningococcal:** I had no prior reaction to a tetanus toxoid-containing vaccine and am not pregnant. **VIS pub: 1/31/25**

_____**Meningococcal B:** I am not allergic to Diphtheria Toxoid or a previous dose and am between the ages of 10 and 25. **VIS pub: 1/31/25**

_____**MMR (Measles Mumps Rubella):** I have not had a reaction to a prior dose or any vaccine components, am not pregnant, do not have acute febrile illness or a weakened immune system. **VIS pub: 1/31/25**

_____**Pneumonia: (Prevnar20)** I am over 6 weeks and not allergic to Prevnar or diphtheria toxoid and am not sick. **VIS pub: 5/12/2023**

_____**Polio:** I was not allergic to a previous dose, neomycin, streptomycin or polymyxin B and am not pregnant.. **VIS pub: 1/31/25**

_____**TD**(Tetanus, Diphtheria): Same as TDAP below contraindications. **Tenivac or Td is given for those 7-10. Vis pub: TD 8/6/2021**

_____**TDAP** (Tetanus, diphtheria and pertussis): I am not allergic to aluminum phosphate, formaldehyde, glutaraldehyde, 2-phenoxyethanol or a prior DTaP vaccine and have not had encephalopathy, or progressive neurological disorder. **Vis pub: TDAP 1/31/25**

_____**Varicella (Chicken Pox):** I have not had a reaction to a prior dose or any vaccine components, am not pregnant, do not have acute febrile illness or a weakened immune system. **VIS pub: 1/31/25**

Patient Information Section -ALL PATIENTS MUST FILL OUT BOX BELOW

_____ _____ _____ ___/____/____ ___ ___
Patient Last Name First Name Middle I Birth Date M/D/Y Age Sex

_____ _____ _____ _____ _____-_____-_____
Patient Address: Street City State Zip Daytime Phone Number

_____/_____ _____ _____ ___/____/_____ ___
Insured ID Group# **Insured** Last Name First Name Birth Date M/D/Y Sex

_____ _____/ _____-_____-_____
Signature of person receiving vaccine or Guardian Emergency Contact Person Emergency Phone #

If you have any questions, please ask now or check with your physician before receiving the vaccine. I understand the benefits and risks of these vaccinations and request those indicated above to be given to me. If you experience any significant reactions, see your physician. Please note that by signing this form you are accepting responsibility for all costs not covered by your insurance. There is a $25.00 service charge for returned checks.

For Clinic Use Only below this point:

Vaccine Administered (nurse checks box by vaccine given)	**Lot #**	**Expir:**	**Amount/Site**	**Injection Site**
DTAP ☐ ☐**Daptacel(SP)** (6 wks to 7 yrs) 2,4,6, 15-18mos, 4-6yrs			**0.5 ml IM**	**Left Right**
HPV ☐ **Gardasil 9 (Merck) (**9-14 or15-45) 0, 6 to 12 mos or 0, 2, 6 mos			**0.5 ml IM**	**Left Right**
Haemophilus Influenzae Type B ☐ **(SP)** (6wks-5yrs) 2,4, 6 and 12 to15 mos, If>15mos, 1dose			**0.5 ml IM**	**Left Right**
Hepatitis A ☐**Havrix (GSK),**☐ **Vaqta (Merck)(**1yto 100yrs) 12-23 mos, 6 mos later, Catch-up is 0,6 mos.			**1.0 ml >18y IM** **0.5 ml ≤ 18y IM**	**Left Right**
Hepatitis B ☐**Energix (GSK)** ☐**Recombivax (Merck)** (brith-100yrs) Birth, 1-2 mos and 6-18 mos, Catch-up is birth,1-2 mos and 6 mos			**1.0 ml > 19y IM** **0.5 ml ≤ 19y IM**	**Left Right**
Meningococcal ☐**MenQuadfi (SP) (2yr+)** 11-12and16yr			**0.5 ml IM**	**Left Right**
Men B ☐ **(Bexsero) (GSK) (10-25yr)** (0, 6 mos)			**0.5 ml IM**	**Left Right**
MMR ☐ **MMRII(Merck)** 12-15 mos, 4-6 yrs. Catch-up 0,4 wks			**0.5 ml SC**	**Left Right**
Pneumonia ☐**Prevnar20 (Pfizer)** (2 mos-5yrs) 2,4,6, and 12-15 mos. 6-17yrs 1dose.			**0.5 ml IM**	**Left Right**
Polio ☐**IPOL (SP)** (6wks-100yrs) 2, 4, 6 to 18 mos, and 4-6 yrs,			**0.5 ml SC**	**Left Right**
Tetanus Diptheria ☐**Tenivac (SP)** 1 every 5-10 yrs ☐**Td (Grifols) (**every 10 yr)			**0.5 ml IM**	**Left Right**
TDAP ☐**Boostrix (GSK)** (10 and up) ☐**Adacel(SP)** (10yr-64yrs), 1 every 5-10yrs			**0.5 ml IM**	**Left Right**
Varicella ☐ **Varivax(Merck)**(2 mos-50yrs) 12-15 mos , 4-6 yrs. Catch-up 0,4-12wks			**0.5 ml SC**	**Left Right**

Nurse Signature: RN VIS/Vaccine Date: Payment Amount: CASH ZELLE MCD CHIP INSUR BILL

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: Passport Health 4700 Dexter Dr #300 Plano TX 75093
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 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). ImmTrac2 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. For more information, see Texas Health and Safety Code § 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 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; 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 DSHS, ImmTrac2.

State law permits the inclusion of immunization records for first responders and their immediate family members in ImmTrac2.
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 § 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. (Reference: Tex. Gov. Code, § 552.021, 552.023, 559.003, and 559.004)

PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in the Texas Immunization Registry and affirm that consent has been granted. **DO NOT** fax to **ImmTrac2**. **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 Department of State Health Services
Immunization Section

Stock No. C-7
Revised 02/2024