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

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.

Date	Eligible for TVFC Vaccine				State Eligible		Not Eligible
	A	B	C	D	E	F	G
	Medicaid Enrolled ID#:_____ Eligibility Date: _____	No Health Insurance	American Indian or Alaskan Native	*Underinsured	For Private Providers only- Not applicable at this event.	**CHIP enrolled	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)

Patient's Name (Last)	(First)	(M.I.)	**Pt. Date of Birth** month____day_____year _____		
Parent/Legal Guardian Name (Last)	(First)	(M.I.)	**Pt. Age**	**Pt. Gender** M ☐ F ☐	**Pt. Hispanic:** Yes ☐ No ☐
Address			**Race: White** ☐ **Black** ☐ **Asian** ☐ **Alaskan** ☐ **American Indian** ☐ **Pacific Islander** ☐ **Other**_____		
City	**State**	**Zip**	**Parent/Guardian Phone Number:**		
Parent Email:			**Appointment Notification Preference:** ☐ **Email** ☐ **Phone Call** ☐ **Text**		**Immtrac2:**

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.

	Yes	No
1.Is the patient sick today?	☐	☐
2. Does the patient have **any** serious **allergies**? Please List: _____	☐	☐
3. Has the patient ever had a serious reaction to vaccine in the past?	☐	☐
4. Has the patient had health problem with lung, heart, kidney or metabolic disease, (e.g., diabetes), asthma, or blood disorder? Is he/she on long-term aspirin therapy?	☐	☐
5. If the patient to be vaccinated is between the ages of 2 and 4 years, has a healthcare provider told you that the patient had wheezing or asthma in the past 12 months?	☐	☐
6. If your patient is a baby, have you ever been told he or she has had intussusception?	☐	☐
7. Has the patient, a sibling, or a parent had a seizure; has the child had brain or other nervous system problem?	☐	☐
8. Does the patient have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐

(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?	☐	☐
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?	☐	☐
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: _____	☐	☐
12. Has the patient received vaccinations in the past 4 weeks?	☐	☐

Section 4: Consent

CONSENT FOR PATIENT'S VACCINATION:

have read or had explained to me the most recent Vaccine Information Statement for the vaccinations I initialed below an nderstand the risks and benefits of vaccination. I acknowledge that I have received a copy of the Texas Department of Stat lealth 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 o be vaccinated with the following vaccines:

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

dap/DTaP_____	Hep. B_____	Hib_____	PCV13_____	Influenza_____
olio_____	Rotavirus_____	MMR*_____	Varicella*_____	MCV4_____
lep A_____	HPV*_____	Men B_____	Other_____	PPSV23__

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

Must be a handwritten signature)

Relationship to Patient: _____

OR 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						05/12/23
	DTaP/DT/Td/Tdap						08/06/21
	Hib						08/06/21
	PCV13						02/04/22
	IPV						08/06/21
	RV						10/15/21
	MMR *						08/06/21
	Varicella *						08/06/21
	MCV4						08/06/21
	Other						08/06/21
	Hepatitis A						10/15/21
	HPV *						08/06/21
	PPSV23						10/30/19
	Influenza						08/06/21
	Men B						08/06/21

DSHS Field Office Stamp:

Not Valid Unless Signed, Stamped & Dated

Nurse Signature: _____ **Date:** _____

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

Interpreter: _____

DATE	CLINICAL NOTES:

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

Texas Immunization Registry (ImmTrac2)

Authorization to Release Official Immunization History

First Name _____ Middle Name _____ Last Name _____

Date of Birth: ____/____/____ (mm/dd/yyyy) Gender: ☐ Male ☐ Female

Address _____ Apartment #/Building # _____

City _____ State _____ Zip Code _____ County _____

Please indicate how and where to send this official immunization record.

Name/Organization _____

Address _____ Apartment # / Building # _____

City _____ State _____ Zip Code _____ Telephone Number: ____-____-____

Send official immunization record by: ☐ Fax Number: ____-____-____ ☐ Mail to address above

☐ Email Address: _____

Requestor Information – must complete in entirety

I, _____, authorize the Texas
Print Name (Select the one that applies: Adult Client, Parent, Legal Guardian, Managing Conservator for a child)
Department of State Health Services to release this client's official immunization record from the Texas Immunization Registry. 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*.

Address _____ Apartment # / Building # _____

City _____ State _____ Zip Code _____ County _____

E-mail address (if available): _____ Telephone Number: ____-____-____

Select the relationship that applies between you and the client: ☐ Adult Client/Self ☐ Parent ☐ Legal Guardian ☐ Managing Conservator for a child

_____ _____

Signature of Adult Client (or Parent, Legal Guardian, or Managing Conservator for a child) **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)

For Office Use Only

ImmTrac2 ID#: _____

Date Searched/Released: _____ ☐ Record Released ☐ Record Not Found

By: _____ ☐ Record Found, but No Immunizations Reported

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
Immunizations

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