Client Demographic Form

Date: _____

All Services:

Name: _____
Last Name First Name Middle Initial

Date of Birth: _____ SS#__-__-____ Gender: ☐ Male ☐ Female

Street Address: _____
City State Zip

Mailing Address: _____
City State Zip

Current phone number: _____ ☐ Cell ☐ Home

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Race:

☐ American Indian or Alaska Native	☐ Asian
☐ Black or African American	☐ Native Hawaiian or Other Pacific Islander
☐ White	☐ Other

Texas Vaccines for Children -TVFC - (18 and under) Immunization Services Only:

Parent/Guardian/Individual of Record: _____
(For minors) Last name First name Middle Initial

Relationship to child: _____

Mothers First Name: _____ Mother's Maiden Name: _____

Child has Private Insurance: ☐ Yes ☐ No If yes, does it cover all vaccines? ☐ Yes ☐ No

Child has Medicaid: ☐ Yes ☐ No If yes, eligibility date: _____

Medicaid ID Number: _____

Adult (19 and over) Safety Net Vaccination Services Only:

Has Private Insurance: ☐ Yes ☐ No

☐ I am 19 years of age and I am finishing a vaccine series that I began when I was 18 years of age or younger and eligible under the TVFC Program.

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

Addendum to Influenza (Flu) Vaccine (Inactivated or Recombinant): *What You Need to Know* Vaccine Information Statement

1. I agree that the person named below will get the vaccine checked below.
2. I received or was offered a copy of the Vaccine Information Statement (VIS) for the vaccine listed above.
3. I know the risks of the disease this vaccine prevents.
4. I know the benefits and risks of the vaccine.
5. I have had a chance to ask questions about the disease the vaccine prevents, the vaccine, and how the vaccine is given.
6. I know that the person named below will have the vaccine put in his/her body to prevent the disease this vaccine prevents.
7. I am an adult who can legally consent for the person named below to get the vaccine. I freely and voluntarily give my signed permission for this vaccine.

***STATEMENT: I authorize the release of any medical or other information necessary to process the claim. I also request payment of government benefits to the party who accepts assignment.**

Provider Identification Number: _____

Medicare Beneficiary Identifier (MBI): _____

Vaccine to be given: ☐ Influenza (Flu) Vaccine (Inactivated or Recombinant)

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)

Privacy Notice: I acknowledge that I have received a copy of my immunization provider's HIPAA Privacy Notice.

Information about person to receive vaccine (Please print)					
Name: Last	First	Middle Initial	Birthdate (mm/dd/yy)	Sex (circle one)	
				M	**F**
Address: Street	City	County	State **TX**	Zip	
Signature of person to receive vaccine or person authorized to make the request (parent or guardian):					
X _____			Date: _____		
X _____ Witness			Date: _____		

For Clinic / Office Use Only

Clinic / Office Address:	Date Vaccine Administered:
	Vaccine Manufacturer:
	Vaccine Lot Number:
	Site of Injection:
	Title of Vaccine Administrator:
	Signature of Vaccine Administrator:
	Date VIS Given:

Notice: Alterations or changes to this publication is prohibited.

Instructions: File this consent statement in the patient's chart.

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

Adult Safety Net (ASN) Program

ADULT ELIGIBILITY SCREENING RECORD

PURPOSE: To determine and record eligibility for the DSHS ASN Program. A record of the eligibility status of adults receiving vaccine supplied by DSHS must be maintained either in hard copy by the clinic providing the service or in an electronic system such as TWICES. Hard copies must be maintained for five (5) years. ASN eligibility screening and documentation of eligibility status must take place at each immunization visit to ensure eligibility status for the program.

Date of Screening: _____ / _____ / _____
(mm/dd/yy)

Name: _____
(Last) (First) (Middle initial)

Date of Birth: _____ / _____ / _____ **Gender:** ☐ Male ☐ Female **Veteran:** ☐ Yes ☐ No
(mm/dd/yy)

Important Information for Former Military Service Members

Women and men who served in any branch of the United States Armed Forces, including Army, Navy, Marines, Air Force, Coast Guard, Reserves or National Guard may be eligible for additional benefits and services. For more information, please visit the Texas Veterans Portal at www.veterans.portal.texas.gov.

Eligibility Criteria (Please check only one (1) box below):

☐ I declare that I qualify for vaccines through the ASN Program because I do not have health insurance.

☐ I am 19 years of age and I have been referred to finish a vaccine series that I began when I was 18 years of age or younger and eligible under the Texas Vaccines for Children (TVFC) Program. This option is only available as long as I have not reached my 20th birthday. "Vaccine series" applies to Hepatitis A, Hepatitis B, Human Papillomavirus (HPV), Mumps, Measles, & Rubella (MMR), Varicella, and Meningococcal vaccines.

Referring Provider: _____

Patient Signature: _____ **Date:** _____ / _____ / _____
(mm/dd/yy)

NOTE: Knowingly falsifying information on this document constitutes fraud. By signing this form, I hereby attest that the above information is true and correct. I declare that the person named above is eligible to receive ASN vaccines.

With few exceptions, you have the right to request and to 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 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, and 559.004)

Texas Department of State Health Services
Immunization Unit

Stock No. F11-12842
Revised 07/2022

TEXAS Department of State Health Services

GENERAL CONSENT AND DISCLOSURE

The information in this consent form is given so that you will be better informed about the health care services you will receive. After you are sure you understand the information which will be given about the services and, if you agree to receive the services, you must sign this form to indicate that you understand and consent to the services.

NOTIFICATION: _____
(Name of Health Department)

(Hereafter called the Department) encourages individuals to seek a personal physician for periodic health examinations and for treatment of health problems. The Department clinic services are targeted primarily toward prevention of health problems among those who cannot access a physician. The Department cannot assume the responsibility for payment of medical care received outside this clinic, including the delivery of babies, unless previous written authorization has been given.

DISCLAIMER ON SCREENING: The Department uses screening tests, which are a way to find people who may develop certain common medical problems. Screening tests are valuable because they can find disease early-before it becomes a big health problem. Screening tests do not cover all diseases and may miss some diseases they are supposed to find, so the test results are not final, just one part of a complete exam. Screening tests can alert you to promptly get a medical check-up and treatment from a doctor or health clinic of your choice.

GENERAL CONSENT: I give permission to the Department, its designated staff and other medical personnel providing services under its sponsorship to perform physical assessments or examinations, conduct laboratory or other tests (which may include HIV testing), give injections, medications, and other treatments, and render other health services to the patient identified on this form.

ADDITIONAL CONSENT: In addition to the above general consent, I understand that special consent forms must be read and signed for the following procedures: medications for tuberculosis and Hansen's disease, immunizations and family planning methods.

PRIVACY NOTICE: I acknowledge that I have received a copy of the Department's HIPAA Privacy Notice.

QUESTIONS: I certify that this form has been fully explained to me, that any blank lines have been filled in and that any questions I have had about the services have been answered to my satisfaction.

SIGNATURES: Fill blank lines with NA if not applicable.

Patient's Name _____ Patient's Signature_____

Person Authorized to Consent (if not patient) _____ Relationship_____

Signature _____ Date_____

I decline HIV testing at this time. If so, initial here: _____

SIGNATURES SECTION II: I certify that the person who has the power to consent cannot be contacted and has not previously objected to the service being requested.

Patient's Name _____

Name of Person Giving Consent _____Signature_____

Relationship to Patient _____ Date_____

Address _____

Phone Number_____

SIGNATURES SECTION III:

Counselor Signature _____ Date_____

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

TEXAS IMMUNIZATION REGISTRY (ImmTrac2)
ADULT CONSENT FORM

(Please print clearly)

First Name _____ Middle Name _____ Last Name _____

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

Address _____ Apartment # / Building # _____

City _____ State _____ Zip Code _____ County _____

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

The Texas Immunization Registry is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates immunization records for public health purposes (e.g., giving all doctors treating a patient a central place to see that patient's immunization records). With your consent, your immunization information will be included in ImmTrac2. *For a family member younger than 18 years of age, a parent, legal guardian, or managing conservator may grant consent for participation for that minor by completing the ImmTrac2 Minor Consent Form (# C-7) available for downloading at www.ImmTrac.com.*

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 ImmTrac2, 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.**

State law permits the inclusion of immunization records for First Responders and their immediate family members (older than 18 years of age) in the 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 a family member younger than 18 years of age, a parent, legal guardian, or managing conservator may grant consent for participation as an "ImmTrac2 child" by completing the Immunization Registry (ImmTrac2) Consent Form (# C-7).

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 _____

Date _____ Signature _____

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)

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com

Texas Department of State Health Services • ImmTrac Group • MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in ImmTrac2 and affirm that consent has been granted. **DO NOT fax to ImmTrac2. Retain this form in your client's record.**

Stock No. F11-13366

Revised 07/2019

Screening Checklist for Contraindications to Inactivated Injectable Influenza Vaccination

PATIENT NAME _____

DATE OF BIRTH ____/____/____ (month / day / year)

For patients (both children and adults) to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Does the person to be vaccinated have an allergy to an ingredient of the vaccine?	☐	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐	☐
4. Has the person to be vaccinated ever had Guillain-Barré syndrome?	☐	☐	☐

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

VACCINE INFORMATION STATEMENT

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