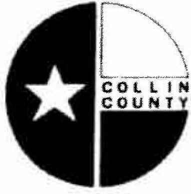

COLLIN COUNTY

Collin County Health Care Services
825 N. McDonald St. Suite 130
McKinney, Texas 75069
www.collincountytx.gov

Time:__________
Date:__________

Immunization Application

Information for person receiving immunization:

ImmTrac, the Texas immunization registry, is a free service of the Texas Department of State and Health Services. The immunization registry is a secure and confidential service that consolidates and stores your child's (under 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac. Doctors, public health departments, schools, and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed.

Texas ImmTrac Registry Consent? Yes No

Child's Name (as it appears on Social Security Card/Legal Name)

Child's Last Name ____________ **Child's First Name** ____________ **Middle Name** ____________

Date of Birth: ____________ (Month / Day / Year) Male ☐ Female ☐ **Social Security Number:**____________

Birth Country:____________ **Mother's Maiden Name:**____________ (Mom's last name before she got married)

Ethnicity:

Alaskan Native American Indian Asian Black / African American Pacific Islander

White / Non-Hispanic White / Hispanic Other____________

Do You Have Insurance or Are You Underinsured? Insured Underinsured

CHIPS Yes No CHIPS Number: ____________ Date of Eligibility: ____________

Medicaid: Yes No Medicaid Number: ____________ Date of Eligibility: ____________

Number of Persons in Household: ________ Household Monthly Income: $____________

Address: ____________ (Number / Street) ________ (Apt) ____________ (City) ________ (Zip Code)

Telephone Number: ____________ Alternate Phone Number: ____________

Responsible Person Name: ____________ Relationship: ____________

Has your child had the chicken pox disease? Yes No If Yes, When____________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that as part of the provisions of healthcare services, Collin County creates and maintains health records and other information describing, among other things, my health and medical history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care of treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that Collin County reserves the right to charge its Notice and practices with regard to the use and disclosure of health information. I understand that I have the right to request restrictions as to how my health information may be used or disclosed for treatment, payment or healthcare operations, but that Collin County is not required to agree to the requested restrictions.

____________ Name (Print) ____________ Signature (Guardian if patient is a minor) ____________ Date

COLLIN COUNTY

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SCREENING QUESTIONNAIRE FOR CHILD AND TEEN IMMUNIZATION

For patients: The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask our healthcare staff to explain it.

Patient Name:	Date of Birth:	Yes	No	Don't Know
1.	Is your child sick today?	☐	☐	☐
2.	Does your child have allergies to medications, food, or any vaccine?	☐	☐	☐
3.	Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
4.	Has the child had a health problem with asthma, lung disease heart disease, kidney disease, metabolic disease (e.g. diabetes), or other blood disorder?	☐	☐	☐
5.	Does the child have cancer, leukemia, AIDS, or any other immune system problem?	☐	☐	☐
6.	Has the child taken cortisone, prednisone, other steriods, anticancer drugs, drugs that decrease your immune system, or had x-ray treatments in the past 3 months?	☐	☐	☐
7.	Has the child had a seizure, brain, or other nervous system problem?	☐	☐	☐
8.	Has the child received a transfusion of blood or blood products, or been given a medicine called immune (gamma) gobulin in the past year?	☐	☐	☐
9.	Is the child/teen pregnant or is there a chance she could become pregnant during the next month? **First day of last menstrual period:**	☐	☐	☐
10.	Has the child received any vaccinations in the past 4 weeks?	☐	☐	☐
11.	If the child to be vaccinated is between the ages of 2 and 4 years, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐	☐	☐

Did you bring your child's immunization record card with you today? Yes No

For females of child bearing age: I understand that if I receive any live virus vaccines during my visit that I should practice birth control of choice for the next four weeks after receiving any live vaccine.

Form completed by: ______________________ Date: ______________________

Form reviewed by: ______________________ Date: ______________________

Texas Department of State Health Services

Addendum to Tetanus, Diphtheria, and Pertussis (Tdap) 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.

Vaccine to be given: ☐ Tdap

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 ______					
______ Date ______ Witness					

For Clinic/Office Use
Clinic/Office Address:
Date Vaccine Administered:
Vaccine Manufacturer:
Vaccine Lot Number:
Site of Administration
Signature of Vaccine Administrator
Title of Vaccine Administrator

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.state.tx.us 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.

Notice: Alterations or changes to this publication is prohibited without the express written consent of the Texas Department of State Health Services, Immunization Branch.

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