Flu Vaccine Consent Form

School Name:			**Teacher/Grade:**	
NAME of Student:	First	Middle Initial	Last	***REQUIRED BY STATE*** **Gender: Male Female**
Birthdate: (MM/DD/YYYY)		**Age**	**Phone #**	**Email**
Address			**Student Race:** (Circle one) ***REQUIRED BY STATE*** African American/Black White Alaskan Native American Asian Hispanic Non-Hispanic Hawaiian/Pacific Islander Other	
City	**Zip Code**	**State**		
Mother's Maiden Name			**Are you, or do you want to be, enrolled in Immtrac (state vaccine database)? YES NO** **New enrollees complete immunization registry on back page.**	

We are required to bill your insurance for our services. Please attach a copy of your insurance, Medicaid, or CHIP card, and complete the insurance box below. All information is confidential.
PLEASE FILL OUT ALL INFORMATION ON THIS FORM AND ON THE TOP HALF OF THE BACK PAGE.

Medicaid ☐	**CHIP** ☐	**NO Insurance** ☐	**Insurance, Medicaid, or CHIP Company:**
Policy Holder's Name:	First	Last	**Policy Holder's DOB (MM/DD/YYYY):**
Member ID / DoD ID (All letters & numbers)		**Group # / Benefits #**	

*CHECK YES OR NO FOR **EACH** QUESTION*

		YES	NO
1	Has the person to be vaccinated ever had a severe or life threatening reaction to the flu vaccine?		
2	Has the person to be vaccinated ever had Guillain-Barre syndrome?		
3	Does the patient have an allergy to eggs?		
4	Does the patient have an allergy to any component of the vaccine?		

ONLY RETURN THIS FORM IF YOU WANT THIS VACCINE

THIS ENTIRE FORM, FRONT, BACK, AND SIGNATURE, MUST BE FILLED OUT OR YOUR CHILD WILL NOT BE VACCINATED

I have read the information about the vaccine and special precautions on the Vaccine Information Sheet. I am aware that I can locate the most current Vaccine Information Statement and other information at www.immunize.org or www.cdc.gov. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I hereby acknowledge that based on the information presented to me, my child is eligible to receive the vaccine(s) on this date. I request and voluntarily consent for the vaccine(s) to be given to the child listed above of whom I am the parent or legal guardian and having legal authority to make medical decisions on their behalf. My child is feeling well today and he/she has not recently had a fever. I accept responsibility for seeking medical attention for any problems associated with receiving the vaccine. I hereby release the school system, Health Hero America LLC, its employees, representatives and agents from any liability for giving the vaccination(s) to my child. I understand this consent is valid for 6 months and that I will make the school aware of any changes in my child's health prior to the vaccination clinic date. Clinic dates may be obtained from the school. I authorize HHA to provide my child's school with documentation of vaccinations given today.

Printed Name of Parent/Guardian	Signature of Parent/Guardian	Relationship to Child	Date

HHA Staff Signature	Date

******AREA FOR OFFICIAL ADMINSTRATION USE ONLY******

Administered by: _____ Location: RA LA

Health Hero America, LLC
244 Flightline Dr.
Spring Branch, TX 78070
mbatey@coldchain-tech.com
210-634-0111

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

REQUIRED

Texas Vaccines for Children 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 (Doctor's) Name: _____ _____
   Last Name First Name
5. Please check the category that applies

- ☐ Is enrolled in Medicaid. Medicaid Number _____ Date of Eligibility_____
- ☐ Is enrolled in the Children's Health Insurance Plan. CHIP Number _____ Group Number _____
- ☐ Is an American Indian or an Alaskan Native
- ☐ Does not have health insurance
- ☐ Is underinsured:
  - ▫ Has commercial insurance, but coverage does not include vaccines
  - ▫ Commercial insurance covers only selected vaccines
- ☐ Underinsured served by FQHC, RHC, or deputized provider
- ☐ Has private insurance that covers vaccines

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MANDATORY FOR NEW IMMTRAC MEMBERS/CHANGE OF INFORMATION

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

IMMUNIZATION REGISTRY (ImmTrac2) Minor
Consent Form

(Please print clearly)

_____ _____
Child's Last Name **Child's Middle Name**

_____
Child's First Name Child's **Child's Gender: Male ☐ Female ☐**

_____/_____/_____ *Children younger than 18 years old only
Date of Birth

_____ _____ _____(_____)_____
Child's Address **Apartment #** **Telephone**

_____ _____ _____ _____
City **State** **Zip Code** **County**

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

ImmTrac2, 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 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.

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

Consent for Registration of Child and Release of Immunization Records to Authorized 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 the state's central immunization registry ("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;
- 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 to include information on my child in the ImmTrac2 Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac Group – MC 1946, P. O. Box 149347, Austin, Texas 78714-9347.

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:

Date _____ Printed Name _____

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)

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