Children's Wellness Center Immunization Form 5301 H Ross Road Del Valle TX 78617

1. _____ M F
Child's Last Name First Name Middle Name Date of Birth Sex

2. _____
Address Apt.# City State ZIP Telephone

3. _____
Parent's or Guardian's Name Relationship to child SIGNATURE OF PARENT

Health Questions:

1. When was the child's last well child checkup? _____
2. Has the child ever had chicken pox? If yes, how old were they? _____ No
3. Is child sick today? Yes No
4. Does child have allergies to medications, food, or vaccines? Yes No
5. Has the child had a serious reaction to a vaccine in the past? Yes No
6. Has the child had a seizure or a brain problem? Yes No
7. Has the child taken cortisone, prednisone, other steroids, or Anti-cancer drugs or had x-ray treatments in the past 3 months? Yes No
8. Has the child received a transfusion of blood or blood products or been given a medicine called immune (gamma) globulin in the past year? Yes No
9. Is the child/teen pregnant, or is there a chance she could become pregnant during the next month? Yes No
10. Has the child received vaccinations in the past 4 weeks? Yes No
11. Has the child ever had a positive reaction to a TB (Tuberculosis) test? Yes No

By signing above, I am stating that:

1. The Children's Wellness Center has my permission to give vaccines to my child today.
2. I give permission to register my child in the local and state immunization registry/database. This means that past, present and future immunization information would be available to the health department, clinics, schools, or other agencies. I can withdraw this consent at any time by writing to the Texas Department of Health.
3. I received or was offered a copy of the vaccine information sheet for each vaccine given today.
4. I have received my immunization providers' privacy notice, called HIPAA.

Insurance: Please check one:

☐ Del Valle ISD student (or sibling)? Yes ☐ No ☐ School name _____
☐ Has Medicaid. Medicaid number: _____
☐ Has MAP/CCHC MAP number: _____
☐ Has CHIP (Children's Health Insurance Program) ID_____
☐ No health insurance or is paying for services
☐ Is an American Indian or Is an Alaskan native
☐ Underinsured (has ins. that does not pay for vaccines or has a co-pay or deductible the family cannot meet)
☐ Has private insurance Ins name_____

Eligibility verified/VIS given
Initials___ Date_____

ImmTrac # _____N
Shots only visit ☐ CWC visit ☐
Tolerated well ☐ Reaction_____
Scheduled WCC appt date_____

DATE:_____ **Vaccinator /Title**:_____ **ORDERING PROVIDER**:_____

VACCINE	Manu-facturer	Lot No. / Exp. Date	Site	VIS date	ICD-9 / CPT	Given By
Hepatitis B Engerix B Peds	GSK	34G75 39A3L FB9RH 02/15/24 02/23/24 01/21/24	LA RA LL RL	10/15/21	V05.3 90744	
DTaP Infanrix	GSK	7KM94 4L9E4 06/10/23 02/07/23	LA RA LL RL	08/06/21	V06.1 90700	
DTAP/IPV/HiB/HepB VAXELIS	Sanofi	U7124AA U7125AA 07/13/24 07/15/204	LA RA LL RL	Multi: 10/15/21		
TDaP Boostrix	GSK	57GJ2 2G3PH 05/29/23 10/27/23	LA RA	08/06/21	V06.1 90715	
Hib Act hib	Sanofi	UJ587AAA UJ579AAA 09/17/22 09/17/22	LA RA LL RL	08/06/21	V03.81 90648	
Pentacel (DTaP/IPV/Hib)	Sanofi	UJ473AAA UJ580AAA 07/09/22 09/10/22	LA RA LL RL	Multi: 10/15/21	V03.81 90698	
Prevnar-13 (Pneumococcal conjug / PCV13)	Pfizer	EJ4562 EM2361 07/31/23 08/31/23	LA RA LL RL	02/04/22	V03.82 90670	
IPV IPOL	Sanofi	U1C571M 01/18/23	LA RA LL RL	08/06/21	V04.0 90713	
MMR	Merck	U006488 U007684 02/26/23 03/09/23	LA RA LL RL	08/06/21	V06.4 90707	
Varicella(VARIVAX) vaccine or history of illness on: _____	Merck	U024220 08/04/23	LA RA LL RL	08/06/21	V05.4 90716	
Hepatitis A VAQTA	GSK	1792241 U024505 10/01/22 10/15/22	LA RA LL RL	10/15/21	V05.3 90633	
Pediarix (DTaP/IPV/HepB)	GSK	Z4R9R J7X44 5N259 05/14/23 05/11/23 10/05/23	LA RA LL RL	Multi: 10/15/21	V06.8 90723	
Proquad (MMR & Varicella) (only 2nd dose of MMR & varicella and only before 13th birthday)	Merck	U009259 U029295 09/19/22 09/19/22	LA RA LL RL	08/06/21	V06.8 90710	
Rotateq	Merck	1741381 1821243 09/04/22 09/22/22	PO	10/15/21	V04.89 90680	
Kinrix (DTaP/IPV combo) 5th DTaP/4th IPV only	GSK	24T2N E2L54 05/07/23 03/03/23	LA RA	Multi: 10/15/21	V06.3 90696	
Meningococcal (MCV4) Enter in ImmTrac as Menactra **Bexsero MenB**	Sanofi	U7191AB U7190BB U7211AA U7140BA **ABXB59AA** 01/18/23 01/21/23 03/14/23 11/07/22 **09/30/22**	LA RA LA RA	08/06/21	V03.89	
HPV9 (gardasil) Enter in IT as HPV9	Merck	1780867 U008900 08/08/23 08/12/23	LA RA	08/06/21	90651 V04.81	
Influenza (flulaval or fluzone) 6 months and up			LA RA LL RL	08/06/21		

PPD Par Lot # exp site: LFA By: Read on: By: MM____ neg pos F/up:

Entered in EMR by: _____ Database: _____ Entered in ImmTrac : _____ Next Due: _____
MH 04-14-2020

Children's Wellness Center Immunization Form 5301 H Ross Road Del Valle TX 7861

1. _____ M F
apellido primer nombre doble nombre fecha de nacimiento Sexo

2. _____
direccion Apt.# Ciudad estado/zip Telefono

3. _____
Nombre de padre/madre o guardian Relacion a nino/nina firma de padre/madre o guardian

Preguntas:

1.	¿Cuándo fue la última chequeo físico del niño? _____		
2.	¿Su niño ha tenido varicela? Si, ¿a que edad? _____		No
3.	¿El niño esta enfermo?	Sí	No
4.	¿Es el niño alérgico a algún medicamento, comida o vacuna?	Sí	No
5.	¿Ha tenido el niño alguna reacción seria a las vacunas en el pasado?	Sí	No
6.	¿Ha sufrido el niño algún ataque o problema del cerebro, o asma?	Sí	No
7.	¿Tiene el niño cáncer, leucemia, SIDA o cualquier otro problema del sistema inmunológico?	Sí	No
8.	¿Ha tomado el niño cortisona, prednisona, otros esteroides, medicamentos anticáncer o ha estado expuesto a un tratamiento con rayos X durante los últimos 3 meces?	Sí	No
9.	¿Esta la niña embarazada o existe la posibilidad de que quede embarazada durante el próximo mes?	Sí	No
10.	¿Ha recibido el niño alguna vacuna durante las últimas 4 semanas?	Sí	No
11.	¿Su niño ha tenido reacción positiva la prueba de TB?	Sí	No

Con mi firma arriba, yo entiendo que:

1. La clínica tiene permiso ha darle vacunas a mi niño

2. Yo doy permiso ha registrar mi niño en el base de datos de la clínica y el estado para las vacunas. Esto quiere decir que la información de las vacunas del pasado, presente, y futuro son disponibles al departamento de salud, las clínicas, escuelas, o otras agencias. Yo puedo al cualquier momento retirar mi permiso nomás escribiéndole al departamento de salud de Tejas.

3. Recibí o se me ofreció una hoja con información sobre cada vacuna.

4. Yo recibido una copia del aviso de la vida privada, HIPAA.

Seguro Medico: Por favor Marque uno:

☐ Es estudiante de Del Valle ISD (o hermano)? Sí ☐ No ☐ Nombre de escuela_____
☐ Tiene Medicaid. Número de Medicaid es:_____
☐ Tiene MAP. Número de MAP es:_____
☐ Tiene seguro de CHIP. Número de CHIP:_____
☐ No tiene seguro o esta pagando por servicios
☐ Es un Indio Americano o Es de Alaska
☐ No tiene seguro médico suficiente (Tiene seguro que **no** pagar para vacunas or tiene un co-pago o un deducible que la familia no puede pagar)
☐ Tiene seguro privado. Nombre de seguro _____

Eligibility verified/VIS given
Initials___ Date_____

ImmTrac # _____N
Shots only visit ☐ CWC visit ☐
Tolerated well ☐ Reaction_____
Scheduled WCC appt date_____

Vacinator/title: _____ Date: _____

VACCINE	Manu-facturer	Lot No. Exp. Date	Site	VIS date	ICD-9 CPT	Given By
Hepatitis B Engerix B Peds	GSK	F22EZ 95SN2 K329E FB9RH 06/03/23 01/01/2022 04/24/24. 01/21/24	LA RA LL RL	10/15/21	V05.3 90744	
DTaP Infanrix	GSK	XG942 7EC55 4L9E4 08/22/22 04/29/23 02/07/23	LA RA LL RL	08/06/21	V06.1 90700	
DTAP/IPV/HiB/HepB VAXELIS	Sanofi	U7124AA 07/13/24	LA RA LL RL	Multi: 10/15/21		
TDaP Boostrix	GSK	33AT7 5S945 GC5NG J39HG 11/07/22 04/06/23 04/01/23 06/05/23	LA RA	08/06/21	V06.1 90715	
Hib	Sanofi	UJ405AAA UJ456AAA UJ587AAA UJ579AAA 10/08/21 05/03/22 09/17/22 09/17/22	LA RA LL RL	08/06/21	V03.81 90648	
Pentacel (DTaP/IPV/Hib)	Sanofi	UJ415AAA UJ473AAA UJ495AAA UJ580AAA 03/12/22 07/09/22 07/09/22. 09/10/22	LA RA LL RL	Multi: 10/15/21	V03.81 90698	
Prevnar-13 (Pneumococcal conjug / PCV13)	Pfizer	EM2361 EM2359 08/31/23 08/31/23	LA RA LL RL	02/04/22	V03.82 90670	
IPV IPOL	Sanofi	T1D482M T1E871M T1E872M 07/25/22 10/10/22 10/10/22	LA RA LL RL	08/06/21	V04.0 90713	
MMR	Merck	U006488. U007684 02/26/23 03/09/23	LA RA LL RL	08/06/21	V06.4 90707	
Varicella(VARIVAX) vaccine or history of illness on: _____	Merck	U024220 08/04/23	LA RA LL RL	08/06/21	V05.4 90716	
Hepatitis A VAQTA	GSK	1792241 U024505 10/01/22 10/15/22	LA RA LL RL	10/15/21	V05.3 90633	
Pediarix (DTaP/IPV/HepB)	GSK	5N259 Z4R9R J7X44 10/05/23 05/14/23 05/11/23	LA RA LL RL	Multi: 10/15/21	V06.8 90723	
Proquad (MMR & Varicella) (only 2nd dose of MMR & varicella and only before 13th birthday)	Merck	U009259 U029295 09/19/22 03/19/23	LA RA LL RL	08/06/21	V06.8 90710	
Rotateq	Merck	1741381 1821243 09/04/22 09/22/22	PO	10/15/21	V04.89 90680	
Kinrix (DTaP/IPV combo) 5th DTaP/4th IPV only	GSK	24T2N E2L54 05/07/23 03/03/23	LA RA	Multi: 10/15/21	V06.3 90696	
Meningococcal (MCV4) Enter in ImmTrac as Menactra **Bexsero MenB**	Sanofi	U7191AB U7190BB U7140BA **ABXB59AA ABXC05AA** 01/18/23 01/21/23 11/07/22 **09/30/22 03/31/23**	LA RA LA RA	08/06/21	V03.89	
HPV9 (Gardasil) Enter in IT as HPV9	Merck	U008900 1780867 08/12/23 08/08/23	LA RA	08/06/21	90651 V04.81	
Influenza (6 months & up)	seasonal		LA RA LL RL	08/06/21		

PPD Par Lot # exp site: LFA By: Read on: By: MM____ neg pos F/up:

Entered in EMR by: ____ Database: ____ Entered in ImmTrac by: ____ Next Due: ____
MH 04-14-2020