



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: _____ Male Female Social Security Number: _____
Month / Day / Year

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 change 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 _____



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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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | Does your child have allergies to medications, food, or any vaccine? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. | Has the child had a serious reaction to a vaccine in the past? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. | Does the child have cancer, leukemia, AIDS, or any other immune system problem? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. | Has the child taken cortisone, prednisone, other steroids, anticancer drugs, drugs that decrease your immune system, or had x-ray treatments in the past 3 months? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. | Has the child had a seizure, brain, or other nervous system problem? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 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: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | Has the child received any vaccinations in the past 4 weeks? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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 Meningococcal 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: Meningococcal Polysaccharide Vaccine (MPSV4)
 Meningococcal Conjugate Vaccine (MCV4)

| Information about person to receive vaccine (Please print) | | | | | | For Clinic/Office Use | |
|---|-------|----------------|-------------------------|-------------------------|-------------------------|------------------------------------|--|
| Name: Last | First | Middle Initial | Birthdate (mm/dd/yy) | Sex (circle one) | | Clinic/Office Address: | |
| | | | | <input type="radio"/> M | <input type="radio"/> F | Date Vaccine Administered: | |
| Address Street | City | County | State TX | Zip | | Vaccine Manufacturer | |
| Signature of person to receive vaccine or person authorized to make the request (parent or guardian): | | | | | | Vaccine Lot Number | |
| x _____ Date _____ | | | | | | Site of Administration | |
| _____ Date _____ | | | | | | Signature of Vaccine Administrator | |
| Witness | | | | | | 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.tdh.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.