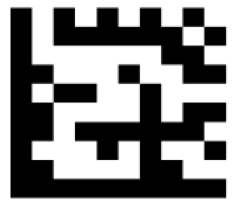
IMMUNIZATION REGISTRY (ImmTrac2)
Minor Consent Form



(Please print clearly)

Child's Last Name

Child's First Name

Child's Middle Name

Child's Date of Birth   ___/___/____   *Children younger than 18 years old only.

Child's Gender: ☐ **Male** ☐ **Female**

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:

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.**

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: Denton County Public Health
(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 N/A

Name of Person Giving Consent N/A Signature N/A

Relationship to Patient N/A Date N/A

Address N/A

Phone Number N/A

SIGNATURES SECTION III:

Counselor Signature ____ Date_________________

Immunization Patient Eligibility Screening: Child

Today's Date: ______ / ______ / ______
(month / day / year)

Child's Name: ______________________ ______________________
(Last / First)

Parent/Guardian: ______________________ ______________________
(Last / First)

Child's Date of Birth: ______ / ______ / ______
(month / day / year)

Please **check the box** for the category that applies. Complete Medicaid, CHIP, or Private Health Insurance information, if applicable. Sign and date at the bottom.

My child...

My child...	
Has MEDICAID	
Has CHIP	
Has NO health insurance	
is an Alaskan Native or American Indian	
Has private health insurance that does not cover vaccines, or only covers certain vaccines	
Has private health insurance that **fully covers vaccines**, or has private insurance that **caps vaccine coverage at a certain amount**	

Clerical Staff Use Only: Program Eligibility	
TVFC	Private Flu/Travel
Verified By (staff initials): ________	

MEDICAID:

Medicaid number: ______________________

Date of eligibility: ______________________

CHIP:

CHIP Number: ______________________

Date of eligibility: ______________________

PRIVATE INSURANCE:

Name of insurer: ______________________

Insurance name: ______________________

Insurer contact number: ______________________

Policy/subscriber number: ______________________

NOTE: Knowingly falsifying information on this document constitutes fraud.
By signing this form, I hereby attest that the information above is true and correct.

SIGNATURE	
DATE	

Screening Checklist for Contraindications to Vaccines Children and Teens

patient name ___________________________

date of birth ______ /_____ /_______
month day year

For parents/guardians: 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 your healthcare provider to explain it.

	Yes	No	Don't Know
1. Is the child sick today? (including fever over 100.4) a. If Yes, please explain:	☐	☐	☐
2. Does the child have allergies to medications, food, a vaccine component, or latex? a. If Yes, please explain:	☐	☐	☐
3. Has the child had a serious reaction to a vaccine in the past? (i.e. anaphylaxis) a. If Yes, please explain:	☐	☐	☐
4. Does the child have lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Is he/she on long-term aspirin therapy? a. If Yes, please explain:	☐	☐	☐
5. If the child to be vaccinated is 2 through 18 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐	☐	☐
6. If your child is a baby, have you ever been told he or she has had intussusception?	☐	☐	☐
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problem? (e.g. Guillain-Barré Syndrome) a. If Yes, please explain who:	☐	☐	☐
8. Does the child or a family member have cancer, leukemia, HIV/AIDS, any other immune system problem, or must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit?) a. If Yes, please explain who:	☐	☐	☐
b. Do they live with or expect to have close contact with that person?	☐	☐	☐
9. In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments? a. If Yes, please explain:	☐	☐	☐
10. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? a. If Yes, please explain:	☐	☐	☐
11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐	☐
12. Has the child received vaccinations or a TB (tuberculosis) test in the past 4 weeks? a. If Yes, please explain:	☐	☐	☐

FORM COMPLETED BY ____ **DATE**_______________

FORM REVIEWED BY ____ **DATE** _______________

Did you bring your immunization record card with you? **yes** ☐ **no** ☐

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.

TECHNICAL CONTENT REVIEWED BY THE CENTERS FOR DISEASE CONTROL AND PREVENTION

Leading our communities to a healthier future.

INFORMED CONSENT TO USE THE DENTON COUNTY PUBLIC HEALTH PATIENT PORTAL

The Patient Portal is a secure, internet-based messaging system that permits you to privately access your medical information and test results maintained by Denton County Public Health (DCPH). The website conforms and complies with the federal law HIPAA (Health Insurance Portability and Accountability). Data is encrypted, which safeguards against any unauthorized use. Only you will have authorized access, using your unique username and password. E-mail addresses, usernames and passwords are never shared by DCPH with other parties.

If you wish to participate in this voluntary service:

1). Read, sign and date this consent form acknowledging you understand and agree to our policy. This must be witnessed and attested to by our staff.
2). Provide us with your written, secure e-mail contact information.
3). You will then receive an e-mail with a unique identification and temporary password, through our electronic medical records vendor *eClinicalworks*.
4). Log in to the Portal website link in the e-mail with your user name and temporary password.
5). Once you are logged in you will have an opportunity to create a new password, and view your test results.

By reading, completing and signing this form I acknowledge that I have read and fully understand the Patient Portal User Agreement and Consent. I Decline Patient Portal Consent ☐

My username and password will not be shared with others, and it is my responsibility to protect these from access by unauthorized persons.

Use of the Denton County Patient Portal System is contingent upon my maintaining satisfactory status as an active patient in DCPH clinics, and this access may be revoked or disabled without prior notification.

To continue patient Portal access, I agree to notify DCPH of any future changes in my e-mail address. I understand that my review and written consent must be updated if/when this policy is modified in the future.

Patient/Guardian Signature:____Date: ______________

Patient name: ____DOB: _______________

Staff Witness:____Date: ______________

Confidential e-mail address (print clearly)____

If the patient is a minor enter name of Parent/Guardian requesting access:

Parent/Guardian: ____Date: _____________

Staff Witness:____Date: _____________