



Texas Immunization Registry (ImmTrac2)
Minor Consent Form



A parent, legal guardian or managing conservator must sign this form if the client is younger than 18 years of age.

Child's First Name, Middle Name, Last Name, Date of Birth, Gender, Telephone, Email address

Child's Address, Apartment # / Building #, City, State, Zip Code, County

Mother's First Name, Mother's Maiden Name

Race (select all that apply), Ethnicity (select only one)

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). The Texas Immunization Registry is a secure and confidential service that consolidates and stores your child's (younger than 18 years of age) immunization records.

Consent for Registration of Child and Release of Immunization Records to Authorized Persons/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 Texas Immunization Registry.

State law permits the inclusion of immunization records for First Responders and their immediate family members in the Texas Immunization Registry. A "First Responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency.

Please mark the box below to indicate whether your child is an Immediate Family Member of a First Responder.
I am an IMMEDIATE FAMILY MEMBER of a First Responder.

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, Signature, Date

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.

PROVIDERS REGISTERED WITH the Texas Immunization Registry: Please enter client information in the Texas Immunization Registry and affirm that consent has been granted. DO NOT fax to the Texas Immunization Registry. Retain this form in your client's record.

Questions? Tel: (800) 252-9152 • Fax: (512) 776-7790 • https://www.dshs.texas.gov/immunize/immtrac/
Texas Department of State Health Services • Immunizations • Texas Immunization Registry – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347



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

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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...

Has MEDICAID	<input type="checkbox"/>
Has CHIP	<input type="checkbox"/>
Has NO health insurance	<input type="checkbox"/>
Is an Alaskan Native or American Indian	<input type="checkbox"/>
Has private health insurance that does not cover vaccines, only covers certain vaccines, or caps vaccine coverage at a certain dollar amount.	<input type="checkbox"/>
Has private health insurance that fully covers vaccines.	<input type="checkbox"/>

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:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the child have allergies to medications, food, a vaccine component, or latex? a. If Yes, please explain:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the child had a serious reaction to a vaccine in the past? (i.e. anaphylaxis) a. If Yes, please explain:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. If your child is a baby, have you ever been told he or she has had intussusception?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Has the child received vaccinations or a TB (tuberculosis) test in the past 4 weeks? a. If Yes, please explain:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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





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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: _____