2018-2019 Seasonal Flu Shot (IIV) Vaccine Consent Form

Full, Legal Name of Student (*First Name Middle Initial. Last Name*) PLEASE PRINT		Name of School	
Parent/Guardian Name (*First Name Middle Initial. Last Name*)	Relationship to Student	Homeroom Teacher / Grade	
Address	Email Address	Birth Date (month / date / year) Age	Sex
City	Zip Code	Home Phone #	Cell Phone #

Please CHECK ONE and fill out the following questions

Insurance ☐ CHIP/STAR/Medicaid ☐ American Indian/Alaskan Native ☐

Underinsured (insurance does not cover Flu vaccine) ☐ My child does not have health insurance $5 Adminstrative Fee requested date of clinic ☐

Insurance Company:	Member ID:
Policy Holder's Name:	Policy Holder's Date of Birth:

The current health care laws require us to bill your insurance company for the vaccine. There will be no out of pocket expense for those insured.

QUESTIONS : CHECK YES OR NO FOR EACH QUESTION

Yes ☐ No ☐ 1.) Is your child 4 years or older?

Yes ☐ No ☐ 2.) Do any of the following apply to your child? *(If you answer YES, your child cannot receive a Flu Vaccine at school - please contact your child's doctor)*

- Allergy to chicken eggs or egg products
- Life threatening reaction(s) to flu vaccine in the past
- Allergy to Latex
- Has had Guillain-Barre syndrome (very rare)

Yes ☐ No ☐ 3.) Do any of the below apply to your child?

Has long-term health problems with weakened immune system, heart disease, lung disease (e.g. cystic fibrosis), liver disease, kidney disease, or metabolic disorders (e.g. diabetes) or blood disorders (e.g. sickle disease or thalassemia)

IF YOU HAVE ANY HEALTH QUESTIONS, PLEASE CONTACT YOUR CHILD'S PEDIATRICIAN
OR CALL AURORA CONCEPTS AT 936-598-3296 TO SPEAK TO A NURSE.

I acknowledge that Aurora Concepts provided me and I have been afforded the opportunity to read the Notice of Privacy Practices and CDC Vaccine Information Statement for the Inactivated Influenza Vaccine (IIV) on their website: www.auroraconcepts.net under the 'Patient Resources' tab.

I give permission to Aurora Concepts and their administrators to give my child the vaccine in my absence, to communicate with other healthcare providers, as needed, and for data entry, billing and storage according to Texas Department of Health policies, to assure optimal healthcare for my child. I hereby release Aurora Concepts, and my child's school district from any and all liability associated with the administration and potential side effects of the vaccine.

☐ **YES, I wish to participate** ☐ **NO, I do not wish to participate**

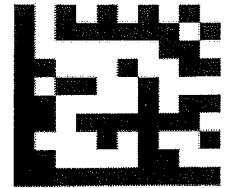
Printed Name of Parent/Guardian ________ Signature of Parent/Guardian ________ Date ________

AREA FOR OFFICIAL USE ONLY FOR ADMINISTRATION

VIS CDC IIV ______ IIV 0.5 ML IM Injection (Flucelvax/Fluzone)	VIS CDC IIV ______ IIV 0.5 ML IM Injection (Flucelvax/Fluzone)
LOT NUMBER ______ EXP DATE ______	LOT NUMBER ______ EXP DATE ______
VACCINE MANUFACTURER ______	VACCINE MANUFACTURER ______
TITLE OF VACCINE ADMINISTRATOR ______	TITLE OF VACCINE ADMINISTRATOR ______
SIGNATURE ______ DATE ______ (RD IM) OR (LO IM)	SIGNATURE ______ DATE ______ (RD IM) OR (LO IM)

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 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.**