University Health System

Registration Form

PATIENT INFORMATION

Event DATE: _____ SOCIAL SECURITY #: _____

Name: LAST: _____ FIRST: _____ MI: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip Code_____

Cell Phone: _____ Alternate Phone:_____

PARENT/LEGAL GUARDIAN INFORMATION:

Name: LAST: _____ FIRST: _____ MI: ____ Date of Birth: _____

Cell Phone: _____ Alterative Phone:_____SOCIAL SECURITY #: _____
Relationship to Patient: ☐ Parent ☐ Spouse OTHER: _____

E-Mail Address: _____

PRIMARY INSURANCE INFORMATION:

Name of Primary Insurance: _____ Telephone #: _____

Subscriber Name: LAST: _____ FIRST: _____ MI: _____

Subscriber Date of Birth: _____ Subscriber SOCIAL SECURITY #: _____
Relationship to Patient: ☐Parent ☐Legal Guardian OTHER: _____

Policy ID/Member #: _____ Group #: _____ Co-payment: _____

Claim Address: _____ City: _____ State: ____ Zip Code: _____

PLEASE CHECK WHICH VACCINES YOU CONSENT STUDENT TO RECEIVE:

MIDDLE SCHOOL	
☐Meningococcal (MCV) (Required)	☐ Tdap (Required)
☐ HPV (Cancer Prevention/Recommended)	☐Flu (Recommended)
HIGH SCHOOL	
☐ Meningococcal (MCV) (Required)	☐Flu (Recommended)
☐ HPV (Cancer Prevention/Recommended)	☐ Meningococcal B (Recommended by most colleges/universities)

Date: _____
Name of Patient: _____
DOB: _____ Age: _____
MRN: _____ VN: _____

University Health System

Vaccination Consent Form

Gender: ☐ Female ☐ Male

Vaccine Name:

[ ] Chickenpox/Varicella
[ ] Diptheria, Tetanus, Pertussis (DTaP)
[ ] Haemophilus Influenza type B conjugate (Hib)
[ ] Hepatitis A (Hep A)
[ ] Hepatitis B (Hep B)
[ ] Hepatitis B Immunoglobulin (IG)
[ ] Human papillomavirus (HPV9)
[ ] Influenza (inactivated) [
] Kinrix® (DTaP-IPV)
[ ] Quadracel® (DTaP-IPV)
[ ] Meningococcal (MCV4)
[ ] Meningococcal type B (Bexsero®)
[ ] Meningococcal type B (Trumenba®)
[ ] Measles, Mumps, Rubella, Varicella (MMRV)
[ ] Measles, Mumps, Rubella (MMR)
[ ] Pediarix® (DTaP-HepB-IPV)
[ ] Pentacel® (DTaP-Hib-IPV)
[ ] Pneumococcal Conjugate/PCV13/Prevnar®
[ ] Pneumococcal Polysaccharide/PPSV/Pneumovax®
[ ] Polio (IPV)
[ ] Rabies
[ ] Rotavirus
[ ] Shingles/Zoster
[ ] Tetanus, Diphtheria, Pertussis (Tdap)
[ ] Tetanus, Diptheria (Td)

The Screening Questionnaire was completed: ☐ Yes ☐ No

CONSENT STATEMENT:

1. I agree that the person named above will get the vaccines indicated and that this person will have a vaccine put into his or her body to prevent infectious diseases.
2. I received or was offered a copy of the Vaccine Information Statement for these vaccines.
3. I know the risks of the diseases this vaccine prevents and the benefits and risks of the vaccine.
4. I have had a chance to ask questions about the diseases, the vaccine, and how the vaccines are given.
5. I am an adult who can legally consent for the person named above to get vaccines. I freely and voluntarily give my signed permission for this vaccine.
6. I give my consent to have this vaccine recorded in the City-wide and State-wide online vaccine databases and that this record can be given to other health care providers, schools, or places that provide child care.

Signature of Patient/Parent/Guardian: _____ Date: _____

Relationship to Patient: _____

Signature / Title of Vaccine Administrator: _____ Date: _____

Witness Signature (Optional): _____ Date: _____

Was an interpreter used? ☐ **Yes** ☐ **No**

Was the consent obtained by telephone? ☐ **Yes** ☐ **No**

If applicable, Name and ID# of Interpreter: _____ Language: _____

Date: _____

Name of Patient: _____

DOB: _____ Age: _____

MRN: _____ VN: _____

University Health System

Vaccination Screening Questionnaire- Adult

1. Are you sick today? ☐ Yes ☐No
   If yes explain: _____
2. Do you have allergies to medications, food or vaccines? ☐ Yes ☐No
   If yes – to what and what happens: _____
3. Have you ever had a serious reaction to vaccines in the past? ☐ Yes ☐No
   If yes to what and what happened: _____
4. Do you have a long-term health problem (ex. Asthma, diabetes, bleeding disorder, seizure or other nervous system disorder)? ☐Yes ☐No
   If yes- explain: _____
5. Do you have cancer, leukemia, AIDs or other autoimmune system problem? ☐ Yes ☐No
   If yes, explain: _____
6. Have you had a seizure, brain or other nervous system problem? ☐ Yes ☐ No
   If yes explain: _____
7. In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments? ☐ Yes ☐ No
   If yes explain: _____
8. During the past year, have you received a blood transfusion or blood products, immune globulin or an antiviral drug? ☐ Yes ☐No If
   yes explain: _____
9. Have you received vaccines in the past 4 weeks? ☐ Yes ☐No
   If yes – what vaccine: _____
10. For women: are you pregnant or is there a chance you could become pregnant in the next month? ☐ Yes ☐ No
    LMP_____ N/A
11. What is your preferred Pharmacy and location?
    _____

TEXAS Health and Human Services | Texas Department of State Health Services

TEXAS IMMUNIZATION REGISTRY (ImmTrac2)
ADULT CONSENT FORM

(Please print clearly)

First Name _____ Middle Name _____ Last Name _____

Gender: ☐ Female ☐ Male

Date of Birth (mm/dd/yyyy) _____ Telephone ( ) _____ Email address _____

Address _____ Apartment # / Building # _____

City _____ State _____ Zip Code _____ County _____

Mother's First Name _____ Mother's Maiden Name _____

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 immunization records for public health purposes (e.g., giving all doctors treating a patient a central place to see that patient's immunization records). With your consent, your immunization information will be included in ImmTrac2. *For a family member younger than 18 years of age, a parent, legal guardian, or managing conservator may grant consent for participation for that minor by completing the ImmTrac2 Minor Consent Form (# C-7) available for downloading at www.ImmTrac.com.*

Consent for Registration and Release of Immunization Records to Authorized Persons / Entities

I understand that, by granting the consent below, I am authorizing release of my immunization information to DSHS and I further understand that DSHS will include this information in the Texas Immunization Registry. Once in ImmTrac2, my immunization information may by law be accessed by: a Texas physician, or other health care provider legally authorized to administer vaccines, for treatment of the individual as a patient; a Texas school in which the individual is enrolled; a Texas public health district or local health department, for public health purposes within their areas of jurisdiction; a state agency having legal custody of the individual; a payor, currently authorized by the Texas Department of Insurance to operate in Texas for immunization records relating to the specific individual covered under the payor's policy. **I understand that I may withdraw this consent at any time.**

State law permits the inclusion of immunization records for First Responders and their immediate family members (older than 18 years of age) in the Registry. A "First Responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency. An "immediate family member" is defined as a parent, spouse, child, or sibling who resides in the same household as the First Responder. For a family member younger than 18 years of age, a parent, legal guardian, or managing conservator may grant consent for participation as an "ImmTrac2 child" by completing the Immunization Registry (ImmTrac2) Consent Form (# C-7).

Please mark the appropriate box to indicate whether you are a First Responder or an Immediate Family Member.

☐ I am a FIRST RESPONDER. ☐ I am an IMMEDIATE FAMILY MEMBER (older than 18 years of age) of a First Responder.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my information in the Texas immunization registry.

Individual (or individual's legally authorized representative): _____ 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.**