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

Vaccination Consent Form

TO THE PATIENT: You have the right to be informed about 1) your condition, 2) the recommended medical care, and 3) the risks related to this vaccine. This disclosure is designed to provide you this information, so that you can decide whether to consent to receive this vaccine. Please ask your vaccination administrator any remaining questions you have before signing this form.

Gender: ☐ Female ☐ Male

Vaccine Name:

[ ] Chickenpox/Varicella
[ ] Covid (1st dose)
[ ] Covid (2nd dose)
[ ] Covid (3rd dose)
[ ] 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)
[ ] Other_____
[ ] 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 and the benefits of the vaccine.
4. I have had a chance to ask questions about 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/EID#:_____ Date: _____

Witness Signature:_____ Date: _____

Was an interpreter used? ☐Yes ☐ No

Was the consent obtained by telephone? ☐ Yes ☐ No

Did the patient give verbal consent while being unable to physically sign? ☐ Yes ☐ No

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

TO BE PLACED IN MEDICAL RECORD
DOWNTIME FORM

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

University Health System

Pediatric Screening Questionnaire

1. Is the child sick today? ☐ Yes ☐ No
   If yes explain: _____
2. Does the child have allergies to medications, food or vaccines? ☐ Yes ☐ No
   If yes – to what and what happens: _____
3. Has the child ever had a serious reaction to vaccines in the past? ☐ Yes ☐ No
   If yes to what and what happened: _____
4. Does the child have a long-term health problem (ex. Asthma, diabetes, bleeding disorder, seizure or other nervous system disorder)?
   ☐ Yes ☐ No
   If yes- explain: _____
5. 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? ☐ Yes ☐ No
   If yes-explain: _____
6. Does the child have cancer, leukemia, AIDs or other autoimmune disorder or is on medication like a cortisone, prednisone, anticancer meds or has X-ray treatments? ☐ Yes ☐No
   If yes, explain: _____
7. Has the child received a blood transfusion or blood products or immune globulin in the past year? ☐ Yes ☐ No
   If yes explain: _____
8. Has the child received vaccines in the past 4 weeks? ☐ Yes ☐ No
   If yes – what vaccine: _____
9. Is the child pregnant? ☐Yes ☐No
   LMP: _____
10. Has the child ever had the chicken pox disease? ☐ Yes ☐No
    If so, what year? _____ (if the child has had the chicken pox disease they will **NOT** need the varicella immunization)
11. What is your preferred pharmacy? _____

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.**

Stock No. C-7 Revised 09/2017