TEXAS VACCINES FOR CHILDREN (TVFC) PROGRAM
PATIENT ELIGIBILITY SCREENING RECORD

CLINIC USE ONLY:
TVFC Eligible:
☐ Yes ☐ No

____
Screener's Initials

A record of all children 18 years of age or younger who receive immunizations through the Texas Vaccines for Children Program must be kept in the health care provider's office. The record may be completed by the parent, guardian, individual of record, or by the health care provider. TVFC eligibility screening must take place with each immunization visit to ensure the child's eligibility status has not changed. This same record will satisfy the requirements for all subsequent vaccinations, as long as the child's eligibility has not changed. If patient eligibility changes, a new form must be completed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines under the TVFC Program.

Date of Screening: ______________________________
mm/dd/yyyy

Child's Name: ____
Last Name First Name MI

Child's Date of Birth: ______________________________ Age: ______
mm/dd/yyyy

Parent/Guardian/Individual of Record: ____
Last Name First Name MI

Provider's Name/Clinic's Name: ____________________________________ Phone Number: (______) ______________
Area Code + number

Please check the first category that applies; check only one.

(a) ☐ Is enrolled in Medicaid, or

______________________________ ______________________________
Medicaid Number: Date of Eligibility (mm/dd/yyyy)

(b) ☐ Is a patient who receives benefits from the Children's Health Insurance Plan (CHIP), or

______________________________ ______________________________
CHIP Number: Date of Eligibility (mm/dd/yyyy)

(c) ☐ Is an American Indian, or

(d) ☐ Is an Alaskan Native, or

(e) ☐ Does not have health insurance (uninsured), or

(f) ☐ Is underinsured:

☐ 1) has commercial (private) health insurance, but coverage does not include vaccines; or

☐ 2) insurance covers only selected vaccines (TVFC-eligible for non-covered vaccines only); or

☐ 3) insurance caps vaccine coverage at a certain amount. Once that coverage amount is reached, the child is categorized as underinsured.

(g) ☐ Has private insurance that covers vaccines:

Name of Insurer: ____________________________________ Insurer Contact Number: (______) ______________
Area Code + number

Policy/Subscriber Number: ____________________________________ Group Number (if applicable): ______________

NOTE: Knowingly falsifying information on this document constitutes fraud. By signing this form, I hereby attest that the above information is true and correct. I declare that the person named above is an authorized person and is eligible to receive TVFC vaccines.

Signature: ____ Date: ______________________
(mm/dd/yyyy)

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.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Vecino Health Centers
Consent for Treatment on Behalf of a Minor[1]

Name of minor patient: ___________________________ **Date of Birth** ____/____/____

I__________________________________ **(print the name of parent or legally authorized person**) hereby and voluntarily consent to authorize the physicians, mid-level providers (Physician Assistant, Advance Practice Nurse), and dentists, if available on the Center staff at their service locations to provide health care services to the above minor. The services may include routine physical and mental assessment, diagnostic and monitoring tests and procedures, immunizations, routine laboratory work, such as blood, urine, and other studies, x-rays and other imaging studies, heart tracing (EKG), administration of medications, as well as procedures and treatment prescribed by the medical and or dental staff.. The health care series also may include counseling services necessary to receive appropriate services including family planning services as defined by federal regulation. I understand that there are no guarantees being made to me concerning the results of the treatment or the effectiveness of any birth control methods prescribed for the minor.

I have received the "Patient and Center Rights and Responsibilities" and the "Notice of Patients Privacy Rights" and understand those documents. I certify that I fully understand this consent for treatment, use of midlevel providers, release of personal health information and the minor's rights concerning these issues. I understand that this consent is valid and remains in effect as long as the minor is a patient of the Center. I have been given an opportunity to ask questions about the services to be provided by this Center and I believe that I have sufficient information to give this consent.

I am authorized to consent on behalf of the above minor as I am the minor's:

□ Parent

□ Legal Guardian (specify relationship):

________________________________.

A PICTURE ID WILL BE REQUIRED AT CHECK IN FOR THOSE PERSONS AUTHORIZED TO BRING THE CHILD IN. NO EXCEPTIONS

I authorize the following people to consent for medical treatment for my child in my absence:

Name	Relationship to child
______________________.	______________.
______________________.	______________.
______________________.	______________.
______________________.	______________.

I understand that if someone who is not listed above brings the minor in for a visit, his/her appointment will/can be canceled.

______________________________ Signature of Parent or Legal Guardian

______________________________ Witness Signature

______________________________ Print Name

______________________________ Print Name

______________________________ Date Time

______________________________ Date Time

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[1] *A minor is an individual who is unmarried and under 18 years of age, and has not had the disabilities of minority removed by the court*

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

IMMUNIZATION REGISTRY (ImmTrac2)
Minor Consent Form

(Please print clearly)

Child's First Name ______ Child's Middle Name ______ Child's Last Name ______

Child's Date of Birth (mm/dd/yyyy) ____/____/______ *Children younger than 18 years old only.

Child's Gender: ☐ Female ☐ Male

Telephone ____-____-______

Child's Address ______ Apartment # ______ Email address ______

City ______ State ______ Zip Code ______ County ______

Mother's First Name ______ Mother's Maiden Name ______

Race (select all that apply)	Ethnicity (select only one)
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American	☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race	☐ Not Hispanic or Latino
☐ Recipient Refused	☐ Recipient Refused

The Texas Immunization Registry (ImmTrac2) 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 • ImmTrac2 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.**

Harris Health MRN#: _______________
Patient Name: __________________
Date: _________________
For Office Use Only

Child Proxy/Release of Information Form

A proxy can see the MyHealth record of a Harris Health patient other than you. You may ask to see a child's health information if you are the parent or legal guardian of a child under the age of 18. The right to get health information for children ages 13 to 17 may be restricted with a higher level of privacy.

Access to a Child's MyHealth Record

To ask to see the MyHealth record of a child over whom you have legal guardianship, please fill out this form. Please note that only certain information from the child's chart will be seen in the MyHealth record.

Parent/Legal Guardian Information (You must fill out all sections – please print)

Name (Last, First, Middle Initial): ________________________________ Date of Birth: ______________

Street Address: ___________________________ City: _______________ State: ________ Zip: _______

Phone Number: __________________________ Email Address: _______________________________

Relationship to Patient* (*e.g.*, parent, legal guardian) __________________________________

Child's Information (You must fill out all sections – please print)

Please give information for your child. If you have more than one (1) child, please ask for another form.

Name (Last, First, Middle Initial): ____

Date of Birth: ___________________ Provider Name: _____________________________________

Parent/Legal Guardian Statement (Please read, date and sign)

I am asking to see the health information in my child's MyHealth record. I agree that by signing this form, I am giving Harris Health System proof of my authority to see my child's health information. I agree I am the child's parent or legal guardian. My rights to see my child's health information have not been changed by any court of law. The proof I have given to show that I can see my child's health information is true and correct and is the most recent copy.

_______________________________________ _________________
Signature of Parent or Legal Guardian Date

Once your child turns 18, you will no longer be able to see your child's MyHealth record. Your adult child may let you see their MyHealth record by filling out the "Adult Proxy/Release of Information Form".

*A copy of the proper legal proof is needed.