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

Vaccine Consent Form for TVFC

Section 1: Eligibility

Eligibility for immunizations through the Texas Vaccines for Children (TVFC) Program must take place with each immunization visit to ensure eligibility status for the program.

To determine if a child (0-18 years of age) is eligible to receive federal vaccine through the TVFC Program, date and mark the appropriate eligibility category. If column A-D is marked, the child is eligible for the TVFC vaccine provided at this event. **If column E-G is marked** the child is not eligible for TVFC vaccine provided at this event, **STOP HERE** and see your private health care provider for vaccinations.

Date	Eligible for TVFC Vaccine				State Eligible		Not Eligible
	A	B	C	D	E	F	G
	Medicaid Enrolled ID#:____________ Eligibility Date: ______________	No Health Insurance	American Indian or Alaskan Native	*Underinsured	For Private Providers only- Not applicable at this event.	**CHIP enrolled	Has health insurance that covers vaccines.

******Underinsured includes children with health insurance that does not include vaccines or only covers specific vaccine types only eligible for vaccines that are not covered by insurance.***

*****Children enrolled in the State of Texas Children's Health Insurance Program (CHIP), must get vaccines through their CH A $10 administrative fee may be requested.***

Section 2: Information about Patient (Pt.) to Receive Vaccine (please print)

Patient's Name (Last)	(First)	(M.I.)	**Pt. Date of Birth** **month**____ **day**______ **year** ______		
Parent/Legal Guardian Name (Last)	(First)	(M.I.)	**Pt. Age**	**Pt. Gender** **M** ☐ **F** ☐	**Pt. Hispanic:** **Yes** ☐ **No** ☐
Address			**Race: White** ☐ **Black** ☐ **Asian** ☐ **Alaskan** ☐ **American Indian** ☐ **Pacific Islander** ☐ **Other**__________		
City	**State**	**Zip**	**Parent/Guardian Phone Number:**		
Parent Email:			**Appointment Notification Preference:** ☐ **Email** ☐ **Phone Call** ☐ **Text**		**Immtrac2:**

Section 3: Screening for Vaccine Eligibility

The following questions will help us to know if the patient can get their recommended vaccinations. If you answer "**YES**" to one or more of the following questions, additional questions may be asked by the nursing team.

	Yes	**No**
1.Is the patient sick today?	☐	☐
2. Does the patient have **any** serious **allergies**? Please List: ______________________________	☐	☐
3. Has the patient ever had a serious reaction to vaccine in the past?	☐	☐
4. Has the patient had health problem with lung, heart, kidney or metabolic disease, (e.g., diabetes), asthma, or blood disorder? Is he/she on long-term aspirin therapy?	☐	☐
5. If the patient to be vaccinated is between the ages of 2 and 4 years, has a healthcare provider told you that the patient had wheezing or asthma in the past 12 months?	☐	☐
6. If your patient is a baby, have you ever been told he or she has had intussusception?	☐	☐
7. Has the patient, a sibling, or a parent had a seizure; has the child had brain or other nervous system problem?	☐	☐
8. Does the patient have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐

(Please continue to the back to complete Vaccine Consent Form)

Patient's Name: ______________________________ **DOB:** ____________________

Section 3: Screening for Vaccine Eligibility Continued

	Yes	No
9. In the past 3 months, has the patient taken medications that weaken their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or any radiation treatments?	☐	☐
10. In the past year, has the patient received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral?	☐	☐
11. Is the patient pregnant or is there a chance she could become pregnant during the next month? ***Date of Last Menstrual Period**, if applicable: ____________________	☐	☐
12. Has the patient received vaccinations in the past 4 weeks?	☐	☐

Section 4: Consent

CONSENT FOR PATIENT'S VACCINATION: I have read or had explained to me the most recent Vaccine Information Statement for the vaccinations I **initialed below** and understand the risks and benefits of vaccination. I acknowledge that I have received a copy of the Texas Department of State Health Services Notice of Privacy Practices.

☐ I **GIVE CONSENT** to the Texas Department of State Health Services and its staff for the patient named on this form to be vaccinated with the following vaccines:

Legally authorized person must initial by each vaccine they wish the patient to receive.

Tdap ______

MCV4 ______

Signature of Legally Authorized Person: ________________________ **Date:** ________________

(Must be a handwritten signature)

Relationship to Patient: ____________________________

FOR OFFICE USE ONLY:

Section 5: Nursing Immunization Documentation

*****ACCESS LMP***(if applicable)** ____________________

Date	Vaccine Hepatitis B	Mfg.	Lot No	Site Given	Given by	Date VIS Given	VIS Date
	DTaP/DT/Td/Tdap						10/15/21
	Hib PCV13 IPV RV						8/6/21
	MMR * Varicella *						8/6/21
	MCV4 Other						2/4/22
	Hepatitis A HPV *						8/6/21
	PPSV23 Influenza						10/15/21
	Men B						8/6/21
							8/6/21
							8/6/21
							10/15/21
							8/6/21
							10/30/19
							8/6/21
							8/6/21

DSHS Field Office Stamp:

DSHS Gainesville
1714 Justice Center Blvd., Suite A
Gainesville, TX 76240
940-665-9315 Opt. 5

Not Valid Unless Signed, Stamped & Dated

Nurse Signature: ________________________ **Date:** ______________

(Signature above indicates immunization given according most current SDO's)

Interpreter: ____________________________

DATE	CLINICAL NOTES: