All sections highlighted in yellow below must be completed by parent/guardian – signature/consent must also be provided.

Care Van® Program

Child's Name
Last: **First:** **Middle:** **Gender:** **M or F** **Race:** **Birth Date:** **Age:**

Address: **Apt#:** **City:** **State:** **Zip:** **County:** **Phone:**

↑ Name of Child's School **↑ (PLEASE PRINT) Full Name of Parent/Guardian Completing this Form**

SCREENING QUESTIONS: Parents/Guardian Circle YES or NO for EACH question

1. Is Child **sick** today? YES NO
2. Does Child have **allergies** to medications, food, a vaccine component or latex? YES NO
3. Has Child had a **serious reaction** to a vaccine in the past? YES NO
4. Does/Has Child have health problems with **lung**, **heart**, **kidney** or **metabolic disease**? YES NO
5. If the child is a baby, have you ever been told he/she has had **intussusception**? YES NO
6. Has the child had a seizure or brain disorder? Any family history of seizures? YES NO
7. Does the child have **cancer**, **leukemia**, **AIDS** or any other **immune system** problem? YES NO
8. In the past 3 months, has the child taken **cortisone**, **prednisone**, or other **steroids** or **Anti-cancer drugs** or had **radiation treatments**? YES NO
9. In the past year, has child received a **transfusion** of blood or blood products or been given **immune (gamma) globulin** or an **antiviral drug**? YES NO
10. Is the child/teen **pregnant**? Is there a chance she could become pregnant in next month YES NO
11. Has the Child had vaccines/**shots in last 4 weeks**? YES NO
12. Has the Child had **Chickenpox**, if so when? YES **Month/Yr** _____ NO

Screener's Signature **(to verify parent/guardian responses):** _____

Please check only one:

( ) Medicaid ( ) No Insurance ( ) American Indian or Alaskan Native ( ) Underinsured

Underinsured: (1) has insurance that does not pay for vaccines (2) insurance only covers selected vaccines (TVFC-eligible for non-covered vaccines only) (3) insurance caps vaccines, child eligible when coverage amount is reached. *Other underinsured are children not eligible to receive vaccine because provider is not a FQHC /RHC or deputized provider. However, these children may be served by a state program that covers these non-VFC eligible children.

*****Fully privately insured children are not eligible for TVFC vaccines including children with CHIP*****

PARENT/GUARDIAN CONSENT:

I received or was offered a copy of a **Vaccine Information Statement** for each vaccine I initialed below and have answered the Screening Questions on this form. I know the risks of the disease each vaccine prevents and the benefits and risks of each vaccine. I have had a chance to ask about the disease, the vaccines, and how the vaccines are given. I know that the child receiving vaccines will have them put into his/her body. **I am an adult who can legally consent for the child named above to receive the vaccines. I voluntarily give my permission for, and consent to, administering the vaccines I initialed below to the child named above.** I release and hold harmless Care Van® Program and Caring for Children Foundation of Texas, Inc. from any and all liability related thereto.

_____
X ↑ Parent/Guardian Signature

_____
↑ Date

_____
↑ Relationship to Child

Date Vaccine Given / Date VIS Given	Parent Initials	Vaccine Given	Brand/Type	Lot #	Site Used (Circle Below)	VIS Date	Nurse/Admin Initials
		Rotavirus *6 - 32wks* *Do not start after 15 weeks*	GSK Merck		LA RA LL RL	10/30/2019	
		Pentacel *6wk- <5y* *DTAP / IPV / HIB*	Sanofi		LA RA LL RL	11/5/2015	
		HIB *<5y*	Sanofi		LA RA LL RL	4/02/2015	
		PCV-13 *<5y*	Wyeth		LA RA LL RL	11/5/2015	
		HEP B *0-18y*	GSK/Merck		LA RA LL RL	8/15/2019	
		DT *6wk-6y* *Hx seizures*	Sanofi		LA RA LL RL	4/01/2020	
		KINRIX *4-6y* *5th DTAP* **AND** *4th or 5th IPV*	GSK		LA RA LL RL	11/5/2015	
		DTAP *6wk-6y*	GSK Sanofi		LA RA LL RL	5/17/2007	
		IPV (Polio) *6wk-18y*	Sanofi		LA RA LL RL	4/01/2020	
		MMR *1-18y*	Merck		LA RA LL RL	10/30/2019	
		MMRV *4-12y (2nd dose only)*	Merck		LA RA LL RL	2/12/2018	
		Varicella *1-18y*	Merck		LA RA LL RL	8/15/2019	
		HEP A *1-18y*	GSK/Merck		LA RA LL RL	8/15/2019	
		Td *7-9y* **or** *Hx of Seizures*	Sanofi		LA RA LL RL	4/01/2020	
		Tdap *10-18y*	GSK/Sanofi		LA RA LL RL	4/01/2020	
		HPV *9-18y*	Gardasil-9		LA RA LL RL	10/30/2016	
		MCV4 *1 dose before age 16 and one dose after16*	Menactra Menveo		LA RA LL RL	8/15/2019	
		Flu - PEDI ONLY ***>6 months thru 35 months***			LA RA LL RL	8/7/2015	
		Flu - *3 years and up*			LA RA LL RL	8/7/2015	

Vaccine Administrator's Signature: Form: HGI-0620

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, ImmTrac2 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)

Upon completion, please fax or mail form to the DSHS ImmTrac2 Group or a registered Health-care provider.

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.**

Demographic Survey

The Care Van® program is able to offer our services a no charge due to the generosity from foundations and individuals. In order to get funding from these groups, we need to know who we serve. Please help us by completing this form for each person receiving care today. Please know that this information will not identify you or your child in any manner.

Ethnicity

☐ Asian/Pacific Island ☐ American Indian/Alaskan ☐ Hispanic
☐ White not Hispanic ☐ Black not Hispanic

Insurance Status

☐ The currently do not have insurance
☐ We have insurance but it does not include the services/ or my out of pocket cost is prohibitive
☐ I have insurance and they will cover the service. I cannot get the treatment during a time that works for me at a provider's office.

Gender

The person receiving care today considers themselves: ☐ M ☐ F ☐ Other

Income

What is the annual income for your household

☐$0-24,0000 ☐$24,001-$31,980 ☐$31,981-$50,000
☐$50,001-$70,000 ☐$70,001-$90,000 ☐Over $90,000

Other information

If the child is enrolled in school, please let us know what school district/Charter Name:
_____

Is anyone in your family on free/reduce lunch at school? ☐ Yes ☐ No

Food assistance program? ☐ Yes ☐ No

If you have received Services from us in The past, please tell About your Experience:

_____
_____
_____
_____
_____