



# Brazoria County Health Department

**Alvin**  
(281) 585-3024

**Angleton**  
(979) 864-1484

**Clute**  
(979) 265-4446

**Manvel**  
(281) 756-2440

**Pearland**  
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**Brazoria**  
(979) 798-5806

## CHILD FORM

### General Consent and Authorization Form

Acknowledgement of review of Notice of Privacy Practices of the Brazoria County Health Department.

-Office Use Only-

Age: \_\_\_\_\_

ImmTrac#: \_\_\_\_\_

Vaccines Needed:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In: \_\_\_\_\_ Out: \_\_\_\_\_

Number: \_\_\_\_\_

**Child's Last Name:** \_\_\_\_\_

**Child's First Name:** \_\_\_\_\_

**Child's Middle Name:** \_\_\_\_\_

**Child's Date of Birth:** \_\_\_\_\_ **Male**  **Female**

**Birth Mother's Maiden Name:** \_\_\_\_\_ **Mother's First Name:** \_\_\_\_\_

**Child's Social Security No. (Optional):** \_\_\_\_\_

**Child's Medicaid Number:** \_\_\_\_\_ **Eligibility Date:** \_\_\_\_\_

**Adult with Child Today:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_  
(Please Print Name) (Mother, Father, Guardian, etc.)

**Street Address:** \_\_\_\_\_ **Telephone** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **County:** \_\_\_\_\_ **Zip code:** \_\_\_\_\_

**Country of Birth:** \_\_\_\_\_

**Race:**  Asian  Black/African American  White  Hispanic  Alaska Native  American Indian  
 Pacific Islander  Other

**Primary Physician:** \_\_\_\_\_

**Adult Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 (mo.) (day) (yr.)

# Screening Questionnaire for Child and Teen Immunization

**For parents/guardians:** The following questions will help us determine which vaccines your child may be given today. If you answer “yes” to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Is the child sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the child have allergies to medications, food, a vaccine component, or latex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the child had a serious reaction to a vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Does the child have cancer, leukemia, AIDS, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. In the past 3 months, has the child taken cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Has the child received vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Form completed by: \_\_\_\_\_ Date: \_\_\_\_\_  
 Form reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

**Did you bring your child's immunization record card with you?**      **yes**     **no**

It is important to have a personal record of your child's vaccinations. If you don't have a personal record, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep this record in a safe place and bring it with you every time you seek medical care for your child. Your child will need this important document for the rest of his or her life to enter day care or school, for employment, or for international travel.

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

**CLINIC USE ONLY:**

TVFC Eligible:

Yes  No

A record must be kept in the office of the health care provider that reflects the status of all children 18 years of age or younger who receive immunizations through the Texas Vaccines for Children Program. The record may be completed by the parent, guardian, or individual of record. This same record may be used for all subsequent visits as long as the child's eligibility status 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 eligibility screening record for each child receiving vaccines under the TVFC Program.

Date of Screening: \_\_\_\_\_

Child's Name: \_\_\_\_\_  
Last Name First Name MI

Child's Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
mm/dd/yy

Parent/Guardian/Individual of Record:  
\_\_\_\_\_  
Last Name First Name MI

Provider's/Clinic's Name:  
\_\_\_\_\_

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

- (a) Is enrolled in Medicaid, or
- (b) Does not have health insurance (uninsured), or
- (c) Is an American Indian, or
- (d) Is an Alaskan Native, or
- (e) Is a patient who receives benefits from the Children's Health Insurance Plan (CHIP), 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.

**Fully, privately insured children are no longer eligible for TVFC vaccine.**

- (g) Has private insurance that covers vaccines (not TVFC eligible).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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### Form only for females 9 years and older.

- Chicken Pox (Varicella)**
- Measles, Mumps and Rubella (MMR)**
- Meningococcal Conjugate ((MCV4)**
- Tdap/TD**
- Human Papillomavirus Vaccine (HPV)**
- Polio (IPV)**
- Hepatitis A (HepA)**

**Pregnant women should not receive these vaccines because it is unknown whether they might cause harm to your unborn baby.**

*Please take extra care in reading the Vaccine information sheet for further information*

- I AM PREGNANT.**
- I AM NOT PREGNANT, I WANT THE IMMUNIZATION LISTED ABOVE AND I UNDERSTAND THAT I MUST WAIT AT LEAST 3 MONTHS BEFORE BECOMING PREGNANT.**

Date: \_\_\_\_\_ Patient Signature: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_