TARRANT COUNTY PUBLIC HEALTH
Influenza Vaccination Consent Form

Payment Type:
Invoice Amount: _____

Patient's Information (Please Print)					
Last Name:	First Name:			Middle Name:	
Street Address:	Apt #	City:	State:	Zip Code:	County:
Date of Birth: ___/___/_____(Month/Day/Year)	Sex: M / F	Age:	Phone Number ( )		
Race:	Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown				
Emergency Contact Name:			Emergency contact Phone ( )		

Consent for Registration and Authorization for Electronic Exchange and Release of Immunization Information

Authorization for the electronic exchange of information to health care providers. Information about you may be released to health care providers for continuing medical care. Your information will be kept confidential, as required by law. You agree that TCPH and its employees, officers and physicians are released from legal responsibility and liability for the release of information as permitted with this consent. This consent will remain in place unless it is withdrawn. You have the right to withdraw this authorization at any time by writing to TCPH Privacy Officer, 1101 S. Main Street, Fort Worth TX 76104. Withdrawing your consent will only apply to future uses of your information. Information may have been used in good faith prior to the receipt of any withdrawal request.

✘ _____ I have read the statements above and authorize the release of health information from TCPH to health care providers.
Initial

Screening Checklist for Today's Immunizations	
1. Is the person/child to be vaccinated sick today?	**Yes No**
2. Does the person/child have allergies to medications, eggs, food, a vaccine component, or latex?	**Yes No**
3. Has the person/child had a serious reaction to a vaccine or the intranasal influenza (FluMist) vaccine in the past?	**Yes No**
4. Does the person/ child have a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she receiving aspirin therapy or aspirin-containing therapy?	**Yes No**
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**
6. Does the person/child have cancer, leukemia, HIV/AIDS, or any other immune system problem; or, in the past 3 months, has the person/ child taken medications that weaken their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?	**Yes No**
7. Has the person/child, a sibling, or a parent had a seizure; has the person/child had brain or other nervous system problems? Has the person/child ever had Guillain-Barré syndrome?	**Yes No**
8. In the past year, has the person/child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	**Yes No**
9. Is the person/child/teen pregnant or is there a chance she could become pregnant during the next month?	**Yes No**
10. Has the person/ child received vaccinations in the past 4 weeks?	**Yes No**

Consent Statement

I have read the CDC Vaccine Information Statement about influenza and the influenza vaccine. I have had a chance to ask questions to my satisfaction. I understand the benefits and risks of the Influenza Vaccine and request that the vaccine be given to me or to the person named above for whom I am authorized to make the request. I have received information about the HIPAA privacy notification.

By signing this form, I hereby attest that this information is true and correct.

Signature: ➔_____ **Date:** _____

Vaccine	Dose/Series	Site	Manf.	Lot #	VIS Date	Date VIS Given

_____ X_____ _____
__Date of Administration **Vaccine Administrator Signature/Title** **Location**