University Health

Thinking beyond

Patient Name:_____ DOB_____

School:_____

# VACCINE DRIVE INFORMATION

***IN ORDER TO BE VACCINATED STUDENTS ARE REQUIRED THE FOLLOWING:***

1. Completed forms **(No parent required to be present if forms completed).**
   a. Page1-2: Demographic, insurance information, and health screening questions. (A parent/legal guardian signature is **REQUIRED** on page 2)
   b. Page 3: IMMTRAC form, this gives us consent to upload vaccines given to the state registry. (Signature is **REQUIRED** at the end of page)
   c. **If student is 18 years of age or older student must sign all forms.**

2. Vaccine record (request from school nurse if needed).

***Things to know for day of event:***

1. Parents will receive a confirmation phone call 24 hours prior to event.
2. If students on campus and complete packet received, student will be pulled from class (Please check with school nurse for class excuse)

***The following vaccines are strongly recommended. Please read information below and initial box if you choose for your student to receive any or ALL three vaccines below:***

☐ **Meningitis B (16 years and up):**

- Vaccine not required by the state, however, required by certain universities.
- 62% of current cases of Meningitis are Meningitis B.
- 2 dose series; one now and one in 1 month.

☐ **HPV (9 years and up):**

- Helps prevent infections that can cause cancer in both male and females
- Children ages 11–12 years should get two doses of HPV vaccine, given 6 to 12 months apart.
- HPV vaccines can be given starting at age 9 years.
- Children who start the HPV vaccine series on or after their 15th birthday need three doses, given over 6 months

☐ **Influenza (Flu):**

- Everyone 6 months and older should get a flu vaccine every season, especially those with chronic illnesses such as asthma.
- Flu vaccination prevents illnesses, medical visits, hospitalizations, and deaths.

**Please contact your school nurse with any questions or concerns**

University Health Mobile Department

(210)358-7020

MRN:_____
CSN:_____
(Patient Label)

# University Health

## Mobile Vaccination Administration Services (Mobile, Pharmacy and School Based Clinics)

**Section A *(please print clearly)***

**First Name:**_____ **Last Name:** _____ **DOB:**_____
**SS#:**_____ **Gender:**☐Male ☐Female
**Home Address:**_____ **City**_____ **State**_____ **Zip**_____
**Cell Phone #:** _____ **Alternate Phone #:** _____
**UH will send immunization information from this visit to your primary care provider (PCP) using the contact information below.**
Do you have a PCP? ☐ No ☐ Yes PCP: _____ Phone Number: _____

**Vaccine requested (Office Use Only):**

[ ] Chickenpox/Varicella
[ ] Covid (1st dose)
[ ] Covid (2nd dose)
[ ] Covid (3rd dose)
[ ] Diptheria, Tetanus, Pertussis (DTaP)
[ ] Haemophilus Influenza type B conjugate (Hib)
[ ] Hepatitis A (Hep A)
[ ] Hepatitis B (Hep B)
[ ] Hepatitis B Immunoglobulin (IG)
[ ] Human papillomavirus (HPV9)
[ ] Influenza (inactivated)
[ ] Kinrix® (DTaP-IPV)
[ ] Quadracel® (DTaP-IPV)
[ ] Meningococcal (MCV4)
[ ] Meningococcal type B (Bexsero®)
[ ] Meningococcal type B (Trumenba®)
[ ] Measles, Mumps, Rubella, Varicella (MMRV)
[ ] Measles, Mumps, Rubella (MMR)
[ ] Other_____
[ ] Pediarix® (DTaP-HepB-IPV)
[ ] Pentacel® (DTaP-Hib-IPV)
[ ] Pneumococcal Conjugate/PCV13/Prevnar®
[ ] Pneumococcal Polysaccharide/PPSV/Pneumovax®
[ ] Polio (IPV)
[ ] Rabies
[ ] Rotavirus
[ ] Shingles/Zoster
[ ] Tetanus, Diphtheria, Pertussis (Tdap)
[ ] Tetanus, Diptheria (Td)

**Section B: Primary Insurance Information: *(please print clearly)***

**Name of Primary Insurance:**_____**Telephone #:** _____
**Subscriber Last Name:** _____**Subscriber First Name:** _____**MI:**_____
**Subscriber DOB:** _____ **Subscriber Social Security #:**_____
**Relationship to Patient:** ☐ **Parent** ☐ **Legal Guardian** ☐ **Other:** _____
**Policy ID/Member #:**_____ **Group #:** _____ **Co-Payment:** _____
**Claim Address:**_____**City:**_____**State:**_____**Zip:**_____

**Section C *(The following questions will help us determine your eligibility to be vaccinated today)***

| Circle: | | |
|---|---|---|
| 1. | Is the person to be vaccinated feeling sick today or do they have a moderate to high fever?<br>**Vaccine Administrator Initials:**_____ | YES NO |
| 2. | Does the person to be vaccinated have allergies to medications, food components, vaccine components, or latex?<br>*Ex.: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast, thimerosal* | YES NO |
| 3. | Does the person to be vaccinated have a chronic condition or long term health problem?<br>*Ex.: heart disease, lung disease, asthma, kidney disease, diabetes, blood disorders, or is the patient a smoker?* | YES NO |
| 4. | Has the person to be vaccinated ever had a serious reaction after receiving an immunization? | YES NO |
| 5. | Has the person to be vaccinated ever had a seizure disorder, brain disorder, Guilliain-Barre Syndrome, or a nervous system problem? | YES NO |
| 6. | Is the person to be vaccinated pregnant, considering becoming pregnant in the next month, or breast feeding? | YES NO |
| 7. | Is the person to be vaccinated immunocompromised or on a medicine that affects their immune system? | YES NO |

MRN:_____
CSN:_____
(Patient Label)

University Health

**Mobile Vaccination Administration Services**
**(Mobile, Pharmacy and School Based Clinics)**

**Section D *(COVID VACCINE SPECIFIC QUESTIONS)***

| | | |
|---|---|---|
| 8. | Do you currently have COVID-19 or have you had it in the last 90 days? | YES NO |
| 9. | Have you been treated with antibody therapy specifically for COVID-19 (monoclonal antibodies or convalescent plasma)? | YES NO |
| 10. | Are you allergic to polyethylene glycol (PEG) or Polysorbate? | YES NO |
| 11. | Are you sick today or do you have any of these symptoms: fever, chills, shortness of breath, body aches, or loss of taste/smell? | YES NO |
| 12. | Have you had any vaccinations in the past 14 days? *Ex*: Shingles, flu, pneumonia, TDap, Td, Hep A, Hep B, HPV | YES NO |
| 13. | Have you come in contact with someone who recently had COVID? | YES NO |
| 14. | Have you visited outside of the country in past 90 days? | YES NO |

**Section E (MMR SPECIFIC QUESTIONS)**

| | | |
|---|---|---|
| **15.** | Have you recently had a blood transfusion or received other blood products. You might be advised to postpone MMR vaccination for 3 months or more. | YES NO |
| **16.** | Have you been given any other vaccines in the past 4 weeks. Live vaccines given too close together might not work as well | YES NO |

**Section F *(Please read the section below carefully and sign and date acknowledging that you understand and agree)***

**INITIALS:**_____ I hereby give my consent to UH to administer the vaccine(s) I have requested above. I understand the benefits and risks of receiving this vaccine and have received, read and/or had explained to me the Vaccine Information Statement on the vaccine(s) I have elected to receive. I acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. I acknowledge that I have been advised to remain near the vaccination location for approximately 20 minutes after administration for observation by the administering healthcare provider. On behalf of myself, my heirs, and personal representatives, I fully release and discharge UH , its staff, agents, affiliates, officers, directors and employees from any and all liabilities or claims whether known or unknown arising in any way related to the administration of the vaccine(s) listed above.

**INITIALS:**_____ I understand the purposes/benefits of my state's immunization registry and acknowledge that, depending upon my state law, may prevent disclosure of my immunization to the state registry with a signed Opt-Out.

**INITIALS:**_____ I assign payment of authorized insurance benefits due to me to be paid to University Health. I consent to the release of medical information when necessary for billing, reimbursement, and medical protocol.

**INITIALS:**_____ I am aware an immunization certified student pharmacist or nurse might be administering this vaccine.

**Patient/Parent/Legal Guardian Printed Name:**_____

**Signature:** _____ **Date:** _____

**Parent/Legal Guardian Information (If Applicable):**

**Relationship to Patient:** ☐ **Parent** ☐ **Legal Guardian** ☐ **Other:** _____ **Date of Birth:** _____

**Email Address:** _____ **Social Security #:**_____

**Section G (The following section is to be completed by the health care provider only)**

Vaccine Administrator Name (print) _____ Vaccine Administrator Signature_____

Intern Name (print) _____ Address: _____ Administration Date: _____

| Vaccine | Lot# | Exp Date | Manufacturer | NDC | Dosage | Site | Route | VIS Date | RPh. Initials |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | LA RA | SQ IM | | |
| | | | | | | LA RA | SQ IM | | |
| | | | | | | LA RA | SQ IM | | |

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

# Texas Immunization Registry (ImmTrac2) Minor Consent Form

**A parent, legal guardian or managing conservator must sign this form if the client is younger than 18 years of age.**

Child's First Name _____ Child's Middle Name _____ Child's Last Name _____

Child's Date of Birth (mm/dd/yyyy) _____/_____/_____ Child's Gender: ☐ Male ☐ Female Telephone _____ - _____ - _____ Email address _____

Child's Address _____ Apartment # / Building # _____

City _____ State _____ Zip Code _____ County _____

Mother's First Name _____ Mother's Maiden Name _____

**Race (select all that apply)**

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race
☐ Recipient Refused

**Ethnicity (select only one)**

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Recipient Refused

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). The Texas 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 the Texas Immunization Registry. Doctors, public health departments, schools, and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed. For more information, see Texas Health and Safety Code Sec. 161.007 (d). https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.007.

## Consent for Registration of Child and Release of Immunization Records to Authorized Persons/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 Texas Immunization Registry. Once in the Texas Immunization Registry, 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, and 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 at any time by submitting a completed Withdrawal of Consent Form in writing to the Texas Department of State Health Services, Texas Immunization Registry.

State law permits the inclusion of immunization records for First Responders and their immediate family members in the Texas Immunization Registry. A "First Responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency. An "immediate family member" is defined as a parent, spouse, child, or sibling who resides in the same household as the First Responder. For more information, see Texas Health and Safety Code Sec. 161.00705. https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.00705.

**Please mark the box below to indicate whether your child is an Immediate Family Member of a First Responder.**

☐ **I am an IMMEDIATE FAMILY MEMBER of a First Responder.**

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 _____ 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.texas.gov* for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

**Provider Statement**

**PROVIDERS REGISTERED WITH the Texas Immunization Registry:** Please enter client information in the Texas Immunization Registry and affirm that consent has been granted. **DO NOT** fax to the Texas Immunization Registry. **Retain this form in your client's record.**

**Contact Information**

**Questions?** Tel: (800) 348-9158 • Fax: (512) 776-7790 • www.ImmTrac.com

**Texas Department of State Health Services • Immunizations • Texas Immunization Registry – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347**