

This section for office staff only:

Date: _____

FLU FORM

Time in: _____

Initials: _____

LAST NAME: _____ FIRST NAME: _____ MAIDEN: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____

BIRTH DATE: ___/___/___ SEX: ___ Please Circle: White Hispanic Black Asian Other

SOCIAL SECURITY #: _____ / _____ / _____ PHONE #: _____

COUNTRY OF BIRTH: _____

FOR CHILDREN ONLY

Parent/Guardian's name: _____ Please Circle: Mother Father Guardian
Print Name

Parent/Guardian's signature: _____ Date: ___/___/___

.....

TO BE REVIEWED BY NURSE

	Yes	No	Don't Know
1. Do you have an allergy to eggs or to a component of the vaccine?			
2. Have you had a serious reaction to the influenza vaccine in the past?			
3. Are you sick today?			
4. Do you have a fever?			
5. Have you ever had Guillain-Barre syndrome? (disorder of the nervous system)			

I have had the opportunity to ask questions about the disease and the vaccine.

Client's Signature: _____

Date: ___/___/___

Nurses' Signature: _____

Date: ___/___/___

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
 IMMUNIZATION REGISTRY (ImmTrac)
 CONSENT FORM



(Please print clearly)

Child's Last Name

For Clinic/Office Use

Child's First Name

Child's Middle Name

Child's Date of Birth *Children under 18 years only.

Child's Gender: Male Female

Child's Address

Apartment #

Telephone

City

State

Zip Code

County

Mother's First Name

Mother's Maiden Name

ImmTrac, 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 (under 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac. 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 ("ImmTrac"). Once in ImmTrac, 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 ImmTrac Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac 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.

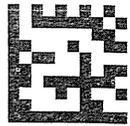
Parent, legal guardian or managing conservator: _____
 Printed Name

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

Questions? (800) 252-9152 • (512) 458-7284 • www.ImmTrac.com
 Texas Department of State Health Services • ImmTrac Group – MC 1946 • P.O. Box 149347 • Austin, TX 78714-9347

Stock No. C-7
 Revised 07/22/08



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

CORPUS CHRISTI – NUECES COUNTY PUBLIC HEALTH DISTRICT

1702 Horne Rd.

Corpus Christi, TX 78416

361-826-7200

Disclosure of Protected Health Information

Our commitment here at CCNCPHD is to serve our customers with professionalism and care, being sure at all times to protect the privacy and security of all Protected Health Information. During the course of serving your interests it may be necessary to share information with other healthcare providers or business associates. The following are examples of instance where information may be shared:

- During treatment, we may find it necessary to acquire a laboratory analysis.
- For payment purposes, we may use the services of a billing service.
- During healthcare operations, we may need a second opinion for consultation with a subcontractor/physician, or need to share information between departments within the Health Department for future programs made available for improving patient care/health issues.

We here at CCNCPHD are committed to obeying all Federal, State and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided for by law. If you have any questions or comment regarding your protected Health Information, feel free to contact our Compliance Officer

The law requires that we protect your health information. We are providing you with a copy of the notice which provides you with information regarding HIPPA. By signing this, you acknowledge that you have received a copy of the Health Insurance Portability and Accountability Act (HIPPA) and that you understand the above Notice of Privacy Practices.

Signed: _____

Date: _____

Printed Name: _____