



(PLEASE PRINT)

Last Name First Name Middle Age

Gender: M/ F Race: Birth Date MM/DD/YY

Address City State Zip County Telephone

Mother's Name Mother's Maiden Name Mother's DOB MM/DD/YY Father's Name

TVFC ELIGIBILITY (Pts. 0-18 yrs. ONLY)

- Enrolled in Medicaid
No Health Insurance
American Indian or Alaskan Native
Patient who receives benefits from CHIP
Underinsured (has private health insurance but coverage does not include vaccines; insurance covers only selected vaccines)
Has private insurance that covers vaccines (not eligible)

PTS. 19 YRS AND OLDER

- No Health Insurance
Private Insurance (BC/BS, Aetna, etc...)

INSURANCE

Medicaid: Yes No
If YES, #
Medicare: Yes No
If YES, #
CHIP: Yes No
If YES, #
WIC: Yes No

MEDICAL HISTORY

- 1. Is Child/Adult Sick Today? Yes No
2. Does Child/Adult have allergies to medications, food and/or vaccine? Yes No
3. Has Child/Adult had a serious reaction to a vaccine? Yes No
4. Does/Has Child/Adult have health problems like asthma, lung, heart, kidney disease, cancer, AIDS and/or any other health problem? Yes No
5. Has Child/Adult had a seizure or a brain disorder? Yes No
6. Has Child/Adult taken cortisone, prednisone, or other steroids, x-rays or anticancer medication in the past 3mths? Yes No
7. Has Child/Adult received a transfusion of blood or blood product or been given immune (gamma) globulin in the past year? Yes No
8. Is the Teen/Adult pregnant or is there a chance she could become pregnancy during the next month? Yes No
9. Has the Child/Adult had vaccines/shots in last 4 weeks? Yes No
10. Has the Child/Adult had Chickenpox, if so when? Yes No
If YES, Month/Day/Year

PARENT/GUARDIAN CONSENT

I received or was offered a copy of the Vaccine Information Statement (VIS) for each vaccine. I know the risks of the disease each vaccine prevents. I know the benefits and risks of each vaccine. I have had opportunity to ask questions about the disease, the vaccines, and how the vaccines are given. I know that the person receiving the vaccine will have the vaccine put into his/her body to prevent the infectious disease. I am an adult who can legally consent for the person named above to get the vaccine. I freely and voluntarily give my signed permission for the vaccines.

May we contact you, either by text message or email, to remind you of future appointments or reminders of when a vaccine is due? (charges may apply depending on your cell ph. plan) YES NO

Ph. Number E-mail address

NOTE: Knowingly falsifying information on this document constitutes fraud. By signing this form, I hereby attest that the above information is true and correct. I declare that the person named above is an authorized person and is eligible to receive TVFC vaccines.

I acknowledge that I have received a copy of the
****Notice of Privacy Practices of the City of El Paso Department Public Health****

Signature: Relationship to the Patient: Date:

*****Clinic Use Only *****

I certify any services for CHIP members will be billed to CHIP Yes No

TVFC Eligible Yes No

Clerk Initials: _____

<u>Date Given</u>	<u>Vaccine Given</u>	<u>Mfg</u>	<u>VIS Date</u>	<u>Lot #</u>	<u>Site Used</u>	<u>Adm. Initials</u>
	Pediarix 6wk-6yrs <i>DTaP/HepB/IPV</i>	GSK				
	KINRIX 4-6yrs <i>DTaP/IPV</i>	GSK				
	Pentacel 6wk-5yrs <i>DTaP-IPV/HIB</i>	Sanofi				
	DTaP 6wk-6yrs	GSK Sanofi				
	HEP A 1-18yrs	GSK Merck				
	HEP B 0-18yrs	GSK Merck				
	PCV-13 <5yrs <i>(6-18 risk based)</i>	Pfizer				
	HIB 6wk-<5yrs	Sanofi				
	Rotavirus <i>6wks-8 months 0 days</i>	Merck				
	IPV 6wk-17yrs	Sanofi				
	ProQuad 1-12yrs <i>MMR/VAR</i>	Merck				
	MMR ≥1yrs	Merck				
	Varicella ≥1yrs	Merck				
	Pedi Flu <i>6mos-18yrs</i>	GSK				
	Flu (≥19 yrs)	Seqirus				
	Hep A (≥19 yrs)	GSK				
	Hep B (≥19 yrs)	Merck GSK				
	Twinrix (≥19 yrs)	GSK				
	HPV 9-26yrs	Merck				
	MCV4 11-21yr <i>(≥2yrs risk based)</i>	Sanofi				
	MEN-B 16-18yr <i>(10-18yrs risk based)</i>	Bexsero—GSK Trumenba-Pfizer				
	PCV-13 <i>ADULT ≥65yrs (19-64 risk based)</i>	Pfizer				
	PNEUMO-23 <i>ADULT ≥65yrs (2-64 risk based)</i>	Merck				
	Tdap (boostrix) ≥7yrs	GSK				
	Tdap (adacel) ≥7yrs	Sanofi				
	Td ≥7yrs	Sanofi				
	Zoster ≥50yrs	GSK				