********** City of El Paso Department of Public Health **********

**(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; insurance caps vaccine coverage at a certain amount. Once that coverage amount is reached, the child is categorized as underinsured)
- Has private insurance that covers vaccines (**not eligible**)

**PTS. 19 YRS AND OLDER**

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

**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:** _____