

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. Page 1-2: 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****

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):

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

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



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 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, Middle Name, Last Name, Date of Birth, Gender, 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) and Ethnicity (select only one) checkboxes

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.

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.

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.

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.

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