Ennis ISD

6th grade Student Immunizations

Alamo Middle School

May 2, 2024

*Please sign up using the following link:
https://form.jotform.com/auroraconcepts/student-vaccine-consent?School=Ennis MS%20ISD

Info for 6th graders – ***MCV4*** (meningitis) and ***Tdap*** (tetanus booster) – **both required** for 7th grade;
HPV optional

Deadline to sign-up: April 29, 2024

*All insurance policies, including Medicaid, will be verified, so please sign up and provide all insurance information using the above link if you plan to participate!

*If you have no insurance and will pay out of pocket, please submit your info! You will put "NA" in all insurance blanks.

No insurance:
18 years old and under - $10/shot
19 years old and above - adult prices - prices will vary depending on vaccine

Aurora Concepts, LLC
233 Hurst St. Suite B
Center, TX 75935
936-598-3296

Vaccine Consent Form

Participation in Student Vaccination Program	
◯ YES, I wish to participate	◯ NO, I do not wish to participate

Full, Legal Name of Student (*First Name Middle Initial. Last Name*)	**Age**	**Birth Date** (month / day / year)	**Sex**
Student Social Security Number (*FOR SUPERIOR MEDICAID ONLY*)	**Name of School**		
Parent/Guardian Name (*First Name Middle Initial. Last Name*)	**Campus**		
Relationship to Student / **Email Address**	**Grade**	**Homeroom Teacher**	
Address			
City / **Zip Code**	**Home Phone #**	**Cell Phone #**	

Insurance Details

Insurance ◯ **CHIP/STAR/Medicaid** ◯ **American Indian/Alaskan Native** ◯

Underinsured (insurance does not cover vaccines) ◯ **My child does not have health insurance** $10/Vaccine Administrative Fee requested date of clinic ◯

Insurance Company: **Member ID:** **Group #**

Policy Holder's Name: **Policy Holder's Date of Birth:**

The current health care laws require us to bill your insurance company for the vaccine. There will be no out of pocket expense for those insured.

Vaccine(s) to be given

☐ HPV ☐ MCV 4 (Required for 11-12 yo and college) ☐ Men B (Recommended 16-18 yo) ☐ Tdap ☐ Varicella

☐ Hep A ☐ Hep B ☐ MMR ☐ IPV ☐ Dtap ☐ Hib

IF YOU HAVE ANY HEALTH QUESTIONS, PLEASE CONTACT YOUR CHILD'S PEDIATRICIAN OR CALL AURORA CONCEPTS AT 936-598-3296 TO SPEAK TO A NURSE.

I acknowledge that Aurora Concepts provided me and I have been afforded the opportunity to read the Notice of Privacy Practices and CDC Vaccine Information Statement for the vaccine(s) indicated on their website: www.auroraconcepts.net under the 'Patient Resources' tab.

I give permission to Aurora Concepts and their administrators to give my child the vaccine in my absence, to communicate with other healthcare providers, as needed, and for data entry, billing and storage according to Texas Department of Health policies, to assure optimal healthcare for my child. I hereby release Aurora Concepts, and my child's school district from any and all liability associated with the administration and potential side effects of the vaccine.

Printed Name of Parent/Guardian _____ Signature of Parent/Guardian _____ Date _____

AREA FOR OFFICIAL USE ONLY FOR ADMINISTRATION

	1	2	3	4	5	6
Clinic/Office Address	Aurora Concepts 233 Hurst St, Ste B Center, TX 75935	Aurora Concepts 233 Hurst St, Ste B Center, TX 75935	Aurora Concepts 233 Hurst St, Ste B Center, TX 75935	Aurora Concepts 233 Hurst St, Ste B Center, TX 75935	Aurora Concepts 233 Hurst St, Ste B Center, TX 75935	Aurora Concepts 233 Hurst St, Ste B Center, TX 75935
Publication Date of VIS						
Date VIS Given						
Vaccine Given						
Date Vaccine Administered						
Vaccine Manufacturer						
Vaccine Lot Number						
Site of Administration						
Signature of Vaccine Administrator						
Title of Vaccine Administrator						

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

Texas Immunization Registry (ImmTrac2)
Adult Consent Form

First Name _____ Middle Name _____ Last Name _____

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

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
☐ Other

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 immunization records. With your consent, your 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 and Release of Immunization Records to Authorized Persons / Entities

I understand that, by granting the consent below, I am authorizing release of my 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, my immunization information may by law be accessed by: a Texas physician, or other health-care provider legally authorized to administer vaccines, for treatment of the individual as a patient; a Texas school in which the individual is enrolled; a Texas public health district or local health department, for public health purposes within their areas of jurisdiction; a state agency having legal custody of the individual; a payor, currently authorized by the Texas Department of Insurance to operate in Texas for immunization records relating to the specific individual covered under the payor's policy. 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 appropriate box to indicate whether you are a First Responder or an Immediate Family Member.

☐ **I am a FIRST RESPONDER.** ☐ **I am an IMMEDIATE FAMILY MEMBER (older than 18 years of age) of a First Responder.**

By my signature below, I GRANT consent for registration. I wish to INCLUDE my information in the Texas Immunization Registry.

Individual (or individual's legally authorized representative):

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)

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.**

Questions? Tel: (800) 252-9152 • Fax: (512) 776-7790 • *https://www.dshs.texas.gov/immunize/immtrac/*
Texas Department of State Health Services • Immunizations • Texas Immunization Registry – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

Texas Department of State Health Services
Immunizations

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