Texas Vaccines for Children Program
Patient Eligibility Screening Record

A record of all children 18 years of age or younger who receive immunizations through the Texas Vaccines for Children (TVFC) Program must be kept in the health care provider's office for a minimum of five years. The record may be completed by the parent, guardian, individual of record, or by the health care provider. TVFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure eligibility status for the program. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines under the TVFC Program.

1. Child's Name:____
   Last Name First Name MI

2. Child's Date of Birth: __ __/__ __/__ __ __ __

3. Parent/Guardian/Individual of Record:________________________________
   Last Name First Name MI

4. Primary Provider's Name:__________ B.K.H.C __________
   Last Name First Name MI

5. To determine if a child (0 through 18 years of age) is eligible to receive federal vaccine through the TVFC program, at each immunization encounter/visit enter the date and mark the appropriate eligibility category. *If Column A-F is marked, the child is eligible for the TVFC program. If column G is marked the child is not eligible for TVFC vaccine.*

	Eligible for VFC Vaccine				State Eligible		Not Eligible
	A	B	C	D	E	F	G
Date	Medicaid Enrolled	No Health Insurance	American Indian or Alaskan Native	*Underinsured served by FQHC, RHC or deputized provider	**Enrolled in CHIP	***Other underinsured	Has health insurance that covers vaccines
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**Underinsured includes children with health insurance that does not include vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance. In addition, to receive VFC vaccine, underinsured children must be vaccinated through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) or under an approved deputized provider. The deputized provider must have a written agreement with an FQHC/RHC and the state/local/territorial immunization program in order to vaccinate underinsured children.*

***Children enrolled in separate state Children's Health Insurance Program (CHIP). These children are considered insured and are eligible for vaccines through the TVFC program as long as the provider bills CHIP for the administration of the vaccine.*

**** Other underinsured are children that are underinsured but are not eligible to receive federal vaccine through the VFC program because the provider or facility is not a FQHC/RHC or a deputized provider. However, these children may be served if vaccines are provided by the state program to cover these non-VFC eligible children.*

Texas Vaccines for Children Program
Patient Eligibility Screening Record
(Continued)

	Eligible for VFC Vaccine				State Eligible		Not Eligible
	A	B	C	D	E	F	G
Date	Medicaid Enrolled	No Health Insurance	American Indian or Alaskan Native	*Underinsured served by FQHC, RHC or deputized provider	**Enrolled in CHIP	***Other underinsured	Has health insurance that covers vaccines
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Medicaid:

Medicaid Number: ______________________

Date of Eligibility: ______________________

CHIP:

CHIP Number: ______________________

Group Number: ______________________

Date of Eligibility: ______________________

Private Insurance:

Name of Insurer: ______________________

Insurance Name: ______________________

Insurer Contact Number: ______________________

Policy/Subscriber Number: ______________________

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

ImmTrac
Texas Immunization Registry

(Please print clearly)

For Clinic/Office Use

Child's Last Name

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)

Upon completion, please fax or mail form to the DSHS ImmTrac Group or a registered Health-care provider.

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com
Texas Department of State Health Services • ImmTrac Group – MC 1946 • P.O. Box 149347 • Austin, TX 78714-9347

Stock No. EC-7
Revised 05/18/2012

TEXAS Department of State Health Services

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.***

Brownsville Kiddie Health Center

Pediatric Health History

Patient Name: ______________________________

DOB: ______________________ Sex: ___M ___F

Pregnancy and Birth

G (Number of Pregnancies) ____ P (Number of Births) ____ AB (Number of Miscarriages and Abortions) ____

Number of living children ____ Mother's age at birth of patient ____ Years between previous pregnancy and this child ____

Prenatal care began in which trimester? 1 2 3 Prenatal care provider ____________

Vitamins: ____Yes ____No Iron: ____Yes ____No Place of birth ____________

Uncomplicated pregnancy, labor, delivery, and nursery course: ____Yes ____No (If yes, proceed to Child's Medical History)

Maternal Complications

__ Dental disease
__ Vaginal bleeding
__ Hypertension
__ Premature labor
__ Flu-like illness or high temperature
__ Kidney or bladder infection
__ Anemia
__ Diabetes
__ STDs
__ Injury / Hospitalization / Surgery
__ Rh negative
__ Exposure to TB
__ Exposure to lead

Maternal Substance Abuse

__ OTC Meds. ____________
__ Prescription Meds. ____________
__ Tobacco ____________
__ Alcohol ____________
__ Street Drugs ____________
__ Caffeine ____________

Birth / Delivery

Place of birth ____________
Birth attendant ____________
Hours of Labor ____________
___ Term
___ Premature (Weeks) ____________
___ More than 2 weeks overdue

Type of Delivery

__ Vaginal
__ C-Section
__ Forceps

Complications

__ Breech
__ Multiple Birth
__ Other

Explanation / Other:

Nursery Course

Birth weight _____ lbs. _____ oz. Birth length _________ Head Circumference (FOC) _________

__ Difficulty w/ initial breathing
__ Heart murmur
__ Infection
__ Transfusion
__ Jaundice req. treatment
__ Seizures
__ Oxygen

Age at discharge _________ ICN _____ days Newborn screening (date / location): ____________

Comments:

Child's Medical History

Immunizations current: ____Yes ____No ____ Record unavailable

Dental care / sealants current: ____Yes ____No

__ Trauma / Injuries
__ Hospitalizations
__ Surgery
__ Medications
__ Anemia
__ Early childhood caries
__ Hepatitis
__ Strep throat
__ Ear infections
__ Bladder / Kidney
__ Infections
__ Pneumonia
__ Developmental delays
__ Vision Problems
__ Hearing problems
__ Seizures
__ Allergies
__ Environmental toxin exposure (lead, etc.)
__ Asthma
__ Eczema
__ Substance use (alcohol, drugs, tobacco)

Explanation / Other:

Family Medical History

Mother's age: _____
Father's Age: _____
Number of siblings: _____

__ Anemia / Blood disorder
__ Heart disease before age 50
__ Cholesterol requiring treatment
__ Hypertension / Stroke
__ Asthma / Allergies
__ Cancer
__ Diabetes
__ Epilepsy / Seizures
__ Kidney problem
__ Muscle disease
__ Bone Disease
__ Childhood hearing impairment
__ Genetic disease or major birth defects
__ Tuberculosis
__ Other immunosuppression
__ Dental decay
__ Alcohol / Drug abuse
__ Tobacco use
__ HIV positive individual in the household (do not identify)
__ Learning disorder
__ Mental retardation
__ Psychiatric disorder
__ Domestic violence
__ Physical / Sexual / Emotional abuse

Explanation / Other:

Family and Social

Child lives with: ___ Mother ___ Father ___ Step Parent ___ Grandparent Other: ____________

Signature of Parent or Guardian: ______________________ Date: ______________

Brownsville Kiddie Health Center

Notice of Privacy Practices

THE FOLLOWING NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE INFORMATION CAREFULLY.

We understand that healthcare information about you is personal. Brownsville Kiddie Health Center is required to maintain confidentiality and to provide you with this notice of legal duties and privacy practices with respect to your healthcare information. A paper copy of this notice is provided to all patients, and revised privacy practices will be presented when necessary.

We may use or disclose your health information for the following reasons:
Treatment – protected health information might be shared with other health care providers.
Payment – protected health information might be used to obtain re-imbursement from insurance companies for the services provided.
Operations – protected health information might be used for the functions within this office, including contacting you about appointments and other reminders.
As required by Law – Federal, state, and local law might require us to release information, such as in cases of suspected child abuse. We might use or disclose information about our patients when necessary to prevent a serious threat to your health or safety or the health and safety of the public of the public or any other person, including other health care providers. The Secretary of Health and Human Services may also request information in necessary.
Public Health Risks – protected health information might be released for public health activities, including: to prevent or control disease, injury or disability; to report reactions to medications or problems with products; to notify people of recalls of products; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease.
Lawsuits and Disputes – if you are involved in any litigation, we may disclose protected health information in response to a court order or administrative order. Protected health information can also be released as a result of a subpoena, discovery request or any other lawful process.
Government Functions – protected health information can be released when it involves (a) health information of military personnel if requested military, (b) health information of inmates, to a correctional institution or law enforcement official, (c) in response to a request from law enforcement, and (d) for national security reasons.

You have the following rights with respect to your protected health information:

1. You have the right to request restrictions on certain uses and disclosures; however Brownsville Kiddie Health Center is not required to agree to all restrictions you request. If Brownsville Kiddie Health Center agrees to restrictions, this will be documented and will follow it per agreement. We cannot agree to limit the uses and disclosure of information that is required by law, or in emergency situations.
2. You have the right to review, inspect and copy your health information. You must submit a written request to Brownsville Kiddie Health Center, and we reserve the right to charge a fee for the costs of copying, mailing and any other administrative costs.
3. You have the right to amend your health information if you feel it is incorrect or incomplete. You must submit a request in writing with reason why you feel information is not accurate. Brownsville Kiddie Health Center cannot agree if in their best professional judgment they feel there is no problem. Any disagreements can be discussed on an individual basis.
4. You are entitled to an accounting for disclosures of you information after April 14, 2003 that was made for any reason other than treatment, payment, operations, legal disclosures, and other government related disclosures. A request must be submitted in writing and time period must not exceed six (6) years.
5. You can request information to be sent to you by alternative means or addresses, such as to a specific address or phone number. However, you must provide us with written request for such actions.
6. If you authorize Brownsville Kiddie Health Center to use or disclose information for any other purpose, you have the right to revoke your authorization in writing at any time.

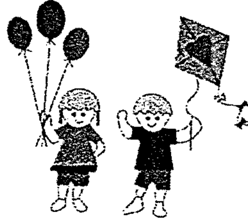
If you have any questions, please contact Brownsville Kiddie Health Center at 95 E. Price Road, Building E, Brownsville, Texas, 78521, or at the phone number 956-504-6080. If you believe your rights have been violated, please contact Brownsville Kiddie Health Center, or the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Brownsville Kiddie Health Center reserves the right to change or amend this Notice of Privacy Practices. It will apply to health information we already have, as well as any information we receive in the future. Revised Notice of Privacy Practices will be posted in our office, and can be provided to you upon request.

Effective Date: April 14, 2003 – Revision 1

Signature: ______________________________ **Date:** ____________________

Brownsville Kiddie Health Center



Carmen D. Rocco, MD
Pediatrics

95. E PRICE RD., BULIDING F, SUITE A – BROWNSVILLE, TX 78521
OFFICE: 956 – 504-6080 FAX 956-5046419

GENERAL CONSENT FOR TREATMENT

I,_____________, AUTHORIZE THE BROWNSVILLE KIDDIE HEALTH CENTER'S MEDICAL PROVIDERS AND HIS/HER ASSISTANTS OR HIS/HER DESIGNEE TO CARRY OUT MEDICAL AND DIAGNOSTIC PROCEDURES THAT MAY BE DEEMED NECESSARY AND/OR ADVISABLE FOR MY CHILD'S HEALTH CARE.

I,________, VOLUNTARILY CONSENT TO THESE SERVICES. I ALSO ACKNOWLEDGE THAT THE PRACTICE OF MEDICINE IS NOT AN EXACT SCIENCE AND THAT NO GUARANTEES HAVE BEEN MADE TO ME AS TO THE RESULT OF SUCH TREATMENT OR EXAMINATION.

===

CONSENTIMIENTO GENERAL PARA TRATAMIENTO

YO, __________, AUTORIZO A LOS MÉDICOS DE BROWNSVILLE KIDDIE HEALTH CENTER Y A SUS ASISTENTES A REALIZAR PROCEDIMIENTOS MÉDICOS Y DE DIAGNÓSTICO QUE PUDIERAN CONSIDERARSE NECESARIOS O ACONSEJABLES PARA EL CUIDADO DE LA SALUD DE MI HIJO/A.

YO,____________,VOLUNTARIAMENTE DOY MI CONSENTIMIENTO PARA ESTOS SERVICIOS. TAMBIÉN ADMITO QUE LA PRÁCTICA DE LA MEDICINA NO ES UNA CIENCIA EXACTA Y NO ME GARANTIZA EL RESULTADO DE TRATAMIENTO O EXAMEN.

____
PATIENT'S NAME/NOMBRE DEL PACIENTE

____
CHART NUMBER

____
SIGNATURE/FIRMA

____
DATE/FECHA

____
RELATIONSHIP TO PATIENT/
RELACIÓN AL PACIENTE

____
BKHC WITNESS/ TESTIGO DE BKHC

Brownsville Kiddie Health Center

"Permission for Medical Health Service & Medical Information."

"Permiso de Servicios Medicos e Informacion Medica"

Patient's Name: ____________________________Date of birth: ___________________________

Nomebre del paciente: ______________________ Fecha de nacimiento: ___________________

*Please list the individuals who you give permission to bring patient to our office for medical health service.
*Por favor liste las personas que usted autoriza a traer al paciente a nuestra oficina para recibir servicios medicos de salud.

Mother/ Madre: _______________________________ Father/Padre:_____________________________

Cell phone #:_______________________________ Cell Phone # :___________________________

Person's Name Nombre de persona	Relationship to the Child Relación con el Niño	Phone Number Num. de teléfono
1.____________________________	1.____________________________	1.____________________
2.____________________________	2.____________________________	2.____________________
3.____________________________	3.____________________________	3.____________________

---

*Please list the individuals who you authorized to access & release Medical Records of the patient.

*Por favor liste las personas que usted autoriza para accede a los Registors Medicos del paciente.

Person's Name Nombre de la Persona	Relationship to the Child Relación con el Niño
1.____________________________	1.____________________________
2.____________________________	2.____________________________
3.____________________________	3.____________________________

_______________________________ _______________________________

Guardian Signature / Firma de la Guardian

Date / Fecha

Brownsville Kiddie Health Center

Carmen Rocco, M.D. (Pediatrics)

PATIENT INFORMATION / INFORMACIÓN DEL PACIENTE			Please Check One: ☐ New Patient / Paciente Nuevo ☐ Updated Information / Nueva Información	
Child's Name / Nombre del Niño	Social Security # Num. Seg. Social	Child's Age Edad del Niño	Sex / Sexo ☐ M ☐ F	Child's Birth Date Fecha de Nacimiento
Child's Home Address / Dirección		City / State / Zip Code Ciudad / Estado / Código Postal		Cell Phone # Num. de Teléfono
In Case of Emergency Contact (Name-Relationship-Phone #) / Un contacto en caso de una emergencia (Nombre-Relación-Num. de Tel.)				
Reffered by: / Quién lo refirió a Ud.?				

RESPONSIBLE PARTY OR GUARANTOR INFORMATION / INFORMACIÓN SOBRE LA PERSONA RESPONSABLE:
Favor de llenar la siguiente sección si el paciente NO es responsable de pagar la cuenta.

Name / Nombre	Sex / Sexo ☐ M ☐ F	Relationship to Patient / Relación con el Paciente ☐ Father Padre ☐ Mother Madre ☐ Other Otro	Birth Date / Fecha de Nac.
Address / Dirección	City / State / Zip Code Ciudad / Estado / Código Postal	Cell Phone / Teléfono	Social Security Num./ Num. de Seguro Social
Employer / Empleador	Employer's Address Dirección del Empleador	Work Phone Num. Tel. de Trabajo	Driver's License Licencia de Manejar

INSURANCE INFORMATION — **Please present insurance card(s) to the Receptionist in addition to completing the area below**
INFORMACIÓN DEL SEGURO — **Por favor presente la tarjeta de seguro al recepcionista y llene el siguiente área**

Insurance Company Name / Nombre de la Compañía de Seguros	Identification # / # Identificación	Group # / # de Grupo
Insurance Company Address (City / State / Zip Code) / Dirección de Compañía de Seguros		
Name of Policy Holder / Nombre del Subscriptor:	Date of Birth / Fecha de Nac.	Relationship to Policy Holder / Relación con el Paciente
Additional Insurance / Seguro Adicional	Identification # / # Identificación	Group # / # de Grupo
Insurance Company Address (City / State / Zip Code) / Dirección de Compañía de Seguros		
Name of Policy Holder / Nombre del Subscriptor:	Date of Birth / Fecha de Nac.	Relationship to Policy Holder / Relación con el Paciente
Medicaid Number / Número de Medicaid		

ADDITIONAL INFORMATION / INFORAMCIÓN ADICIONAL

Please list drugs that your child is currently taking:
Por favor liste los medicamentos que su hijo toma actualmente: ____________________

Allergic to: Es alérgico a: ____________________

Please discuss any serious medical problems that your child has had:
Por favor mencione cualquier problema médico serio que su hijo haya tenido: ____________________

I request that payment of authorized insurance benefits be made on my behalf to the provider indicated above for any services furnished to me. I authorize any holder of medical information about my child to release to the insurance company any information needed to determine these benefits payable for related services. A photocopy of the assignment is to be considered as valid as the original until revoked. I understand that I am financially responsible for all charges whether or not covered by said insurance.

Pido que los pagos de beneficios autorizados por mi seguro sean hechos directamente al proveedor indicado anteriormente por cualquier servicio que he recibido. Autorizo la entrega de cualquier información médica, propia o de mis dependientes, a la compañía de seguro necesaria para que determinen los beneficios o cualquier otro servicio relacionado. Una copia de esta asignación de beneficios será considerada válida como el original hasta ser revocada. Yo entiendo que soy responsable financieramente por todos los cargos y cobros que dicho seguro cubra o no cubra.

X ____________________

Signature of Parent or Guardian / Firma del Padre o Tutor

____

Date / Fecha

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient's Name: ____

Address: ____

Date of Birth: ____

I authorize the following individual or organization to disclose the above named individual's health information:

____

This information may be disclosed to and used by the following individual or organization:
Brownsville Kiddie Health Center / Carmen D. Rocco, MD
95 E. Price RD., Bldg. F, Suite A, Brownsville, TX 78521
Phone #: (956) 504 – 6080 Fax #: (956) 504 – 6419

Last Dr's Phone number
Phone:____________________

Fax :____________________

Information to be released:

☐ All Medical Records ☐ Vaccines

☐ Lab Tests ☐ Other: ____________________

Covering the periods of care from ______________ to ______________

For the purpose of: ____________________________

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
____Yes, I consent to the release of this information ____No, I do not consent to the release of this information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date:

Expiration Date: ____________________________

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I can contact: BKHC at 956-504-6080.

____________________________ ____________________________
Signature of Parent / Legal Representative Date

____________________________ ____________________________
Relationship to Patient Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO THE PATIENT
I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold **Brownsville Kiddie Health Center** liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

____________________________ ____________________________
Signature of Patient or Legal Representative Date

____________________________ ____________________________
Relationship to Patient (If Legal Representative) Witness