

Vaccine Documentation Form

(800)252-9152

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 a chance 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 an infectious disease. I am an adult who can legally consent for the person named below to get the vaccine. I freely and voluntarily give my signed permission for the vaccines.

Recibí o se me ofreció una hoja con información sobre cada vacuna (VIS). Conozco los riesgos de las enfermedades que cada vacuna previene. Conozco los beneficios y riesgos que estas vacunas tienen. He tenido la oportunidad de hacer preguntas sobre las enfermedades, las vacunas y cómo son administradas las vacunas. Sé que la persona recibiendo la vacuna la tendrá en su cuerpo para prevenir una enfermedad contagiosa. Soy adulto y puedo dar permiso legalmente para que le den la vacuna a la persona nombrada abajo. Por mi propia voluntad firmo y doy permiso para que le den esta vacuna.

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.tx.gov> for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Notificación Sobre Privacidad: Tan solo por unas cuantas excepciones, usted tiene el derecho de solicitar y de ser informado sobre la información que el Estado de Texas reúne sobre usted. A usted se le debe conceder el derecho de recibir y revisar la información al requerirla. Usted también tiene el derecho de pedir que la agencia estatal corrija cualquier información que se ha determinado sea incorrecta. Diríjase a <http://www.dshs.tx.gov> para más información sobre la Notificación sobre privacidad. (Referencia: Government Code, Sección 552.021, 552.023, 559.003 y 559.004)

Privacy Notice: I acknowledge that I have received a copy of my immunization provider's HIPAA Privacy Notice.

Aviso sobre derechos de la vida privada: Yo admito haber recibido una copia del aviso sobre derechos de la vida privada.

Yes, HIPAA received No HIPAA received

Si, Recibí HIPAA No Recibí HIPAA

| Hepatitis B | DTaP/DT/DTP/Td/Tdap | Haemophilus influenzae type b (Hib) | Pneumococcal Conjugate (PCV) | Polio (IPV/OPV) (Circle one) | Rotavirus (RV) | Measles, Mumps, and Rubella (MMR) | Measles | Varicella (Chickenpox) | Meningococcal (MCV4/MPSV4) | Hepatitis A | Human Papillomavirus (HPV) | Pneumococcal Polysaccharide (PPSV) | Serogroup B Meningococcal (MenB) | Influenza | Date Fecha | Signature/Relation/Address/Telephone Firma/Relación/Dirección/Teléfono |
|-------------------------------------|---------------------|-------------------------------------|------------------------------|------------------------------|----------------|-----------------------------------|---------|------------------------|----------------------------|-------------|----------------------------|------------------------------------|----------------------------------|-----------|---------------|---|
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| Witness Signature/Firma del Testigo | | | | | | | | | | | | | | | | |
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| Witness Signature/Firma del Testigo | | | | | | | | | | | | | | | | |
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| Witness Signature/Firma del Testigo | | | | | | | | | | | | | | | | |
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| Witness Signature/Firma del Testigo | | | | | | | | | | | | | | | | |

Check vaccines to be given then enter date, sign, and complete the section below.
Señale las vacunas que se van a dar, escriba la fecha, firme y llene la parte de abajo.

Clinic Stamp



TEXAS
Health and Human
Services

**Texas Department of State
Health Services**

| Date | Vaccine | Mfg. | Lot No. | Site Given | Given by | Date VIS Given | VIS Date | |
|------|---|------|---------|------------|----------|----------------|----------|--|
| | Hepatitis B | | | | | | | |
| | Hepatitis B | | | | | | | |
| | Hepatitis B | | | | | | | |
| | DTaP/DT/DTP/Td/Tdap | | | | | | | |
| | DTaP/DT/DTP/Td/Tdap | | | | | | | |
| | DTaP/DT/DTP/Td/Tdap | | | | | | | |
| | DTaP/DT/DTP/Td/Tdap | | | | | | | |
| | DTaP/DT/DTP/Td/Tdap | | | | | | | |
| | DTaP/DT/DTP/Td/Tdap | | | | | | | |
| | Hib | | | | | | | |
| | Hib | | | | | | | |
| | Hib | | | | | | | |
| | Hib | | | | | | | |
| | PCV | | | | | | | |
| | PCV | | | | | | | |
| | PCV | | | | | | | |
| | PCV | | | | | | | |
| | IPV/OPV | | | | | | | |
| | IPV/OPV | | | | | | | |
| | IPV/OPV | | | | | | | |
| | IPV/OPV | | | | | | | |
| | RV | | | | | | | |
| | RV | | | | | | | |
| | RV | | | | | | | |
| | MMR | | | | | | | |
| | MMR | | | | | | | |
| | Measles | | | | | | | |
| | Varicella (Chickenpox) | | | | | | | |
| | Varicella (Chickenpox) | | | | | | | |
| | Varicella History/Date of Varicella Disease | | | | | | | |
| | MCV4/MPSV4 | | | | | | | |
| | MCV4/MPSV4 | | | | | | | |
| | Hepatitis A | | | | | | | |
| | Hepatitis A | | | | | | | |
| | HPV | | | | | | | |
| | HPV | | | | | | | |
| | HPV | | | | | | | |
| | PPSV | | | | | | | |
| | MenB | | | | | | | |
| | MenB | | | | | | | |
| | Influenza | | | | | | | |

 Last/Apellido First/Nombre Middle/Segundo nombre Birth date/Fecha de nacimiento Sex/Sexo

 Address/Dirección () Telephone Number/Número de teléfono Race/Raza

 City/Ciudad State/Estado Zip/Código postal County/Condado

 Social Security Number/Número de Seguro Social Medicaid Number/Número de Medicaid WIC Number/Número de WIC

 Parent's Name/Nombre del padre o de la madre Mother's Maiden Name/Apellido de soltera de la madre