El Paso Department of Public Health
Immunizations

Clinic Use only:

please print

Last Name **First Name** **Middle**

Birth Date (MM/DD/YY) **Age** **Phone #**

Address **City** **State**

Zip Code **County** **Email:**

MOTHER'S FIRST NAME: **MOTHER'S MAIDEN NAME:**

Race:
- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian/Pacific Islander
- ☐ Black or African-American
- ☐ White
- ☐ Other

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Non-Hispanic
- ☐ Recipient Refused
- ☐ Unknown

Gender:
- ☐ Male
- ☐ Female

For clients ages 0-18 ONLY

check only **ONE** of the following:

TVFC Eligibility

- ☐ Enrolled in Medicaid #_____
- ☐ No Health Insurance
- ☐ American Indian or Alaskan Native
- ☐ Enrolled in CHIP #_____
- ☐ Underinsured (private health insurance but coverage does not include vaccines)

For clients ages 19 & up ONLY

check only **ONE** of the following:

ASN Eligibility

- ☐ No Health Insurance
- ☐ Referred to finish a vaccine series that I began when I was 18 years of age or younger and eligible under the TVFC program
- ☐ I qualify for ASN vaccines under a Special Initiative Program/Disaster Relief/Outbreak efforts

FOR COVID-19 VACCINE ONLY:

- ☐ Private insurance - COVID-19 vaccine not covered

Medical and Social History:

1.	Is the patient (Child or Adult) sick today?	YES	NO
2.	Does the child/Adult have allergies to medications, food and/ or vaccines?	YES	NO
3.	Has the Child/Adult had a serious reaction to a vaccine?	YES	NO
4.	Does Child /Adult have health problems like asthma, lung, heart, kidney disease, cancer, AIDS and/or any other health problems?	YES	NO
5.	Has the Child/Adult had any seizures or a brain disorder?	YES	NO
6.	Has the Child/Adult taken cortisone, prednisone, or other steroids, x-rays or anticancer medication in the past 3 months?	YES	NO
7.	Has the Child/Adult received a transfusion of blood or blood product or been given immune (gamma) globulin in the past year?	YES	NO
8.	Has the Child/Adult had vaccines/shots in the last 4 weeks?	YES	NO
9.	Has the Child/Adult had Chickenpox, if yes when? _____	YES	NO
10.	Is the patient a Veteran?	YES	NO
11.	Does the Child/Adult have WIC?	YES	NO
12.	Is the Teen/Adult pregnant or is there a chance she could become pregnant during the next month?	YES	NO
13.	Date of the last normal menstrual period:(mm/dd/yy) _____ Duration: _____ (# days) Normal/Abnormal Consistency: Normal/Abnormal		

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.

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 /ASN vaccines.

Signature: _____ **Relationship to the Patient:** _____ **Date:** _____