Texas Department of State Health Services

Addendum to 2009 H1N1 Live, Attenuated Influenza Vaccine Information Statement

1. I agree that the person named below will get the vaccine checked below.
2. I received or was offered a copy of the Vaccine Information Statement (VIS) for the vaccine listed above.
3. I know the risks of the disease this vaccine prevents.
4. I know the benefits and risks of the vaccine.
5. I have had a chance to ask questions about the disease the vaccine prevents, the vaccine, and how the vaccine is given.
6. I know that the person named below will have the vaccine put in his/her body to prevent the disease this vaccine prevents.
7. 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 this vaccine.

*STATEMENT: I authorize the release of any medical or other information necessary to process the claim. I also request payment of government benefits to the party who accepts assignment.

Vaccine to be given: ☐ 2009 H1N1 LAIV Vaccine

Provider Identification No.: _____ Medicare Health Insurance Claim No.: _____

Information about person to receive vaccine (Please print)				
Name: Last / First / Middle Initial			Birthdate (mm/dd/yy)	Sex (circle one) M F
Mother's First Name (if client is less than 18 years of age)		Mother's Maiden Name (if client is less than 18 years of age)		
Address: Street	City	County	State TX	Zip

Age Group Category: (Check only one please)

☐ **6-23 months** ☐ **24-59 months** ☐ **5-18 years**

☐ **19-24 years** ☐ **25-49 years** ☐ **50-64 years** ☐ **65+ years**

_____ Date: _____
Signature of person to receive vaccine or person authorized to make the request (parent or guardian) (mm/dd/yy)

_____ Date: _____
Witness (mm/dd/yy)

For Clinic/Office Use
Clinic/Office Address:
Date Vaccine Administered:
Vaccine Manufacturer:
Vaccine Lot Number:
Site of Administration: ☐ Nasal _____
Signature of Vaccine Administrator:
Title of Vaccine Administrator:
Dose Number: (Please check one) ☐ **1st** ☐ **2nd** ☐ **Unknown**

Consent for Retention of Disaster-Related Information and Release of Information to Authorized Entities

I understand that, by granting the consent below, I am authorizing retention of my (or my child's) disaster-related information by DSHS beyond the 5 year retention period. I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac"). Once in ImmTrac, my (or my child's) disaster-related information may by law be accessed by:

- a state agency, for the purpose of aiding and coordinating communicable disease prevention and control efforts, and/or
- a physician or other health care provider legally authorized to administer immunizations, antivirals, and other medications, for treating the client as a patient;

I understand that I may withdraw this consent to retain information in the ImmTrac Registry beyond the 5 year retention period 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 to retain my disaster-related information (or my child's information if under age 18) in the Texas immunization registry beyond the 5 year retention period.

Client (or parent, legal guardian or managing conservator): _____
Printed Name

_____ _____
Date (mm/dd/yy) **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)

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

Notice: Alterations or changes to this publication is prohibited without the express written consent of the Texas Department of State Health Services, Immunization Branch.

Instructions: File this consent statement in the patient's chart.