Texas Department of State Health Services
Addendum to Vaccine Information Sheet

1. *I agree that the person name below will get the vaccine checked below.*
2. *I received or was offered a copy of the Vaccine Information Statement (VIS) for the vaccine(s) listed below.*
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 the person named below will have the vaccine put in his/her body to prevent the disease the vaccine prevents.*
7. *I am an adult who can legally consent for the person named below to get the vaccine(s). I freely and voluntarily give my signed permission for this vaccine.*

Patient Name: _____ **Date of Birth**: _____

Patient is: (check one) **Age**: _____

[ ] Enrolled in Medicaid OR [ ] CHIP (Children's Health Insurance Plan)
[ ] Uninsured OR [ ] Underinsured (has insurance that does not pay for vaccines or caps vaccine coverage)
[ ] American Indian OR [ ] Alaskan Native

Vaccine(s) to be given to child **18 YEARS OR YOUNGER**:

[ ] **MMR** 99999-4681-00 (12 months+; *Live*)	[ ] **Varicella** 99999-4827-00 (Chickenpox; 12 months+; *Live*)	[ ] **Flumist** (2 – 49 years old; *Live*)
[ ] **Flu** (influenza) shot (6 months+)	[ ] **Inactivated polio** 99999-0860-10 (IPV; 6 weeks+)	[ ] **Hib** 49281-9999-99 (H. influenza B; 2 months - 5 years)
[ ] **Hepatitis A** 58160-0825-11 (Havrix; 12 month+)	[ ] **Hepatitis B** 00000-0820-00 (Engerix-B; from birth)	[ ] **HPV** 00006-4119-01 (Gardasil-9; 9 to 26 years old)
[ ] **Rotovirus** 00006-4047-99 (Rototeq; 6 weeks to 8 months)	[ ] **Pneumococcal** 00005-1970-26 (PCV13; Prevnar; 6 weeks to 5 years)	[ ] **Pneumococcal** (PPSV23; Pneumovax; 2 years+)
[ ] **DTaP** 49281-0286-10 (diphtheria, tetanus, acellular pertussis; Daptacel; **6 weeks to 7 years**)	[ ] **TDaP** 99999-0400-10 (diphtheria, tetanus, acellular pertussis; Adacel; **over 7 years**)	[ ] **Meningococcal** 99999-0589-05 (MCV4, **Menactra**; 6 weeks+)
[ ] Trumenba **Mening Serogroup B** 10 to 25 years) 00005-0100-10	[ ] Bexsero **Mening Serogroup B** 10 to 25 years) 46028-0114-00/58160-0976-99	

[ ] **Pentacel** 49281-0510-05 (DTap + IPV + Hib; 6 weeks to 4 years)	[ ] **Pediarix** 58160-0841-11 (Hep. B + DTap + IPV; 6 weeks to 6 years)	[ ] **ProQuad** (MMR + Varicella; 1 to 12 years)
[ ] **Kinrix** 58160-0812-11 (DTap + IPV; 4 to 6 years)		

Vaccine(s) to be given to **ADULTS**:

[ ] **MMR** (up to 60 years; *Live*)	[ ] **Varicella** (Chickenpox; 12 months+; *Live*)	[ ] **Shingles** (Zostavax; 60 years+; *Live*)
[ ] **Flu shot** (6 months+)	[ ] **High Dose Flu shot** (65 years+)	[ ] **Inactivated polio** (IPV; 6 weeks+)
[ ] **Hepatitis A** (Havrix; 12 months+)	[ ] **Hepatitis B** (Recombivax; from birth)	[ ] **HPV** (Gardasil-9; 19 to 26 years old)
[ ] **TDaP** (Boostrix, Adacel–up to 64 years; every 10 years)	[ ] **Meningococcal** (MCV4, Menactra; up to 55 years old)	[ ] **Meningococcal Serogroup B** (Trumenba; 10 to 25 years)
[ ] **TB skin test** (Tubersol)	[ ] **Pneumococcal** (PCV13; Prevnar; 50 years+)	[ ] **Pneumococcal** (PPSV23; Pneumovax; 2 years+)
[ ] **Yellow fever** (9 months+)	[ ] **Typhoid oral capsule** (Vivotif; 6 years+)	[ ] **Typhoid injection** (Typhim; 2 years+)

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 the information upon request. You have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.tdh.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.

Texas Department of Health Services (Combined C-96, C-85, EC-87, C-90, C-92, C-106, C-97, C-95, C-108, C-91)

Patient Name:_____
Patient DOB:_____

Contraindication to Vaccines

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:	YES	NO
Eggs, chicken or protein (flu/YF)		
Neomycin (pox, mmr, shingles)		
Gelatin (pox, shingles, YF)		
Yeast (hepB)		
Streptomycin or Polymyxin B (IPV)		
Are you moderately or severely ill (fever, cold)? (All shots)		
Had serious reaction after receiving a vaccination? (All shots)		
Do you have cancer/leukemia, HIV/AIDS or any other immune system problems? (LAIV, MMR, VAR, ZOS)		
Are you on Immunosuppressant med (steroids or chemo)? (LAIV, MMR, VAR, ZOS)		
Have you had seizure or a brain or nervous system problem? (Flu, Td, Tdap)		
Have you received a blood transfusion or blood product, or been given immune (gamma) globulin or an antiviral drug? (LAIV,MMR,VAR)		
Women: Are you pregnant or is there a chance you could become pregnant during the next month? (MMR,LAIV, VAR, ZOS)		
Have you received any vaccinations in the past 28 days? ****If yes, which vaccines:		