



DATE: _____

**DENTON COUNTY PUBLIC HEALTH
535 S. LOOP 288, SUITE 1003
DENTON, TEXAS 76205
940-349-2900 / FAX 877-865-2587**

PATIENT'S INFORMATION:

SS#: _____/_____/_____ MARITAL STATUS: __SINGLE __MARRIED

LAST NAME: _____ FIRST NAME: _____ MI: _____

SEX: __M __F DOB: _____/_____/_____ RACE: _____

RESIDENCY: __US CITIZEN __RESIDENT ALIEN __UNDOCUMENTED

BIRTH COUNTRY: _____ PREFERRED LANGUAGE: _____

MEDICAID #: _____ CHIP #: _____

CERTIFIED FOR SERVICES AS OF: _____/_____/_____

ADDRESS: _____ APT/LOT/TRLR# _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME #: (_____) _____ CELL#: (_____) _____

E-MAIL: _____

PREFERRED METHOD OF CONTACT: __HM# __CELL# __E-MAIL

PREFERRED PHARMACY: _____

IF MINOR (0-18 years):

ADULT RESPONSIBLE: _____ RELATIONSHIP: _____

MOTHER'S NAME: _____ DOB: _____/_____/_____

FATHER'S NAME: _____ DOB: _____/_____/_____



GENERAL CONSENT AND DISCLOSURE

The information in this consent form is given so that you will be better informed about the health care services you will receive. After you are sure you understand the information which will be given about the services and, if you agree to receive the services, you must sign this form to indicate that you understand and consent to the services.

NOTIFICATION: Denton County Public Health
(Name of Health Department)

(Hereafter called the Department) encourages individuals to seek a personal physician for periodic health examinations and for treatment of health problems. The Department clinic services are targeted primarily toward prevention of health problems among those who cannot access a physician. The Department cannot assume the responsibility for payment of medical care received outside this clinic, including the delivery of babies, unless previous written authorization has been given.

DISCLAIMER ON SCREENING: The Department uses screening tests, which are a way to find people who may develop certain common medical problems. Screening tests are valuable because they can find disease early-before it becomes a big health problem. Screening tests do not cover all diseases and may miss some diseases they are supposed to find, so the test results are not final, just one part of a complete exam. Screening tests can alert you to promptly get a medical check-up and treatment from a doctor or health clinic of your choice.

GENERAL CONSENT: I give permission to the Department, its designated staff and other medical personnel providing services under its sponsorship to perform physical assessments or examinations, conduct laboratory or other tests (which may include HIV testing), give injections, medications, and other treatments, and render other health services to the patient identified on this form.

ADDITIONAL CONSENT: In addition to the above general consent, I understand that special consent forms must be read and signed for the following procedures: medications for tuberculosis and Hansen’s disease, immunizations and family planning methods.

PRIVACY NOTICE: I acknowledge that I have received a copy of the Department’s HIPAA Privacy Notice.

QUESTIONS: I certify that this form has been fully explained to me, that any blank lines have been filled in and that any questions I have had about the services have been answered to my satisfaction.

SIGNATURES: Fill blank lines with NA if not applicable.

Patient’s Name _____ Patient’s Signature _____

Person Authorized to Consent (if not patient) _____ Relationship _____

Signature _____ Date _____

I decline HIV testing at this time. If so, initial here: _____

SIGNATURES SECTION II: I certify that the person who has the power to consent cannot be contacted and has not previously objected to the service being requested.

Patient’s Name _____ N/A _____

Name of Person Giving Consent _____ N/A _____ Signature _____ N/A _____

Relationship to Patient _____ N/A _____ Date _____ N/A _____

Address _____ N/A _____

Phone Number _____ N/A _____

SIGNATURES SECTION III:

Counselor Signature _____ Date _____

Screening Checklist for Contraindications to Vaccines for Children and Teens

PATIENT NAME _____

DATE OF BIRTH _____ / _____ / _____
month day year

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer “yes” to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your health care provider to explain it.

	yes	no	don't know
1. Is the child sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the child have allergies to medications, food, a vaccine component, or latex? If yes, explain:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the child had a serious reaction to a vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. If the child to be vaccinated is 2 through 18 years of age, has a health care provider told you that the child had wheezing or asthma in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. If your child is a baby, have you ever been told he or she has had intussusception?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. In the past 1–3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Has the child received vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

Did you bring your immunization record card with you? yes no

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's health care provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.