OFFSITE Midway ISD

Welcome to the Waco-McLennan County Public Health District

Waco-McLennan Public Health

Date: 5-7-26

First Name: _____ **Middle Initial:** _____

Last Name: _____ **Date of Birth:** _____

Title: Ms. Mr. Mrs. Miss. Dr. (circle preferred title)

Sex: M / F (circle biological sex) **SSN:** _____

Gender: _____ **Phone:** _____

Email: _____ (circle one) Mobile Home Work

Street Address: _____

City, State, Zip: _____ **County:** _____

Race: (circle one)
Black
White
Asian
Native Hawaiian or Pacific Islander
American Indian or Alaskan Native
Other: _____

Ethnicity: (circle one)
Hispanic or Latino
Non-Hispanic or Latino

Mother's Maiden Name: (for use in the Texas Immunization database Immtrac2 ONLY)
(first name): _____ (last name): _____

Allergies: _____ **Daily Medications:** _____

Height: _____

Weight: _____ **Primary Doctor:** _____

How can we help you today? _____

Responsible Party (please print name): _____

Payment Options:
(circle the option that corresponds to your status)

A: I have insurance, and am providing my insurance card
This includes CHIP, Medicare, Medicaid, and all private or employer provided insurances.

B: I do not have insurance, or my insurance doesn't cover the requested service

Updated by 11/25 DC

***Please fill in shaded areas
***Por favor llene las areas acentuadas

The client or the client's parental guardian must answer ALL of the following questions before any immunizations will be given.
El cliente o el custodio legal tiene que contestar TODAS las siguientes preguntas antes de recibir inmunizaciones.

(Circle Answer/ Circule las respuestas)

YES / SI NO 1. Is the client sick today or has he/she been sick in the last week?
Esta el cliente enfermo hoy o el/ella a estado enfermo/a en lo ultimo semana?

YES / SI NO 2. Is the client taking any medications? If so, please list them here: _____
El cliente toma alguna medicina? Si responde si, por favor lista aqui: _____

YES / SI NO 3. Does the client have allergies to gelatin/Jello, neomycin, streptomycin, polymyxin B, baker's yeast, eggs, thimerosol, latex, or reaction to immune Globulin?
Tiene el cliente alergias a la gelatina, huevos, neomicina, estrotomicina, polymyxin B, thimerosol, productos que contienen levadura de panadero, productos de latex o reaccion a Globulin Immune?

YES / SI NO 4. Has the client had a serious reaction to a vaccine in the past?
El cliente a tenido alguna reaccion grave a una vacuna en el pasado?

YES / SI NO 5. Has the client had a seizure or other nervous system disorders?
El cliente a tenido convulsiones o otros ataques del sistema nervioso.

YES / SI NO 6. Does the client (or other persons in the home) have cancer, leukemia, AIDS or any other immune system problem?
El cliente o personas que viven en el mismo hogar, tienen SIDA, cancer, leukemia o enfermedades que debilitan el sistema inmunologico.

YES / SI NO 7. Has the client taken cortisone or other steroids, anticancer drugs, or x-ray treatments in the past 3 months?
El cliente a tomado cortisone or otro tipo de esteroides, drogas anticancer, o tratamientos de radiografia en los pasados 3 meses?

YES / SI NO 8. Has the client received a blood transfusion, plasma, or been given a medicine called immune (gamma) globulin in the past 12 months?
El cliente a recibido una transfusion de sangre, plasma, o fue dado una medicina llamada globin inmune (gamma) en los pasados 12 meses?

YES / SI NO 9. Has the client had the chickenpox illness? Or has received the vaccine?
El cliente a tenido la enfermedad de Viruela o a recibido la vaccuna contra la Varicela?

YES / SI NO 10. Has the client had a TB skin test in the past 3 days?
El cliente a recibido una prueba de piel de TB en los pasados tres dias?

YES / SI NO 11. FOR TB SKIN TES: Has the client had a positive TB test in the past or taken TB medications? If so, when? _____
Prueba de tuberculosis: El cliente a recibido una prueba positiva de tuberculosis en el pasado o a tomado medicina para tratar el tuberculosis? Cuando? _____

YES / SI NO 12. Has the client had an immunization in the past 4 weeks?
El cliente a recibido vaccunas en los pasados cuatro semanas?

YES / SI NO 13. Does the client have a family physician? If "NO" see provider list.
Tiene el cliente un doctor familiar? En caso que "NO" por favor vea la lista de proveedores.

YES / SI NO 14. Does the client have a chronic medical condition (regardless of age). Such as:
Asthma or another lung disease? YES/NO Heart disease? YES/NO Diabetes? YES/NO
Kidney disease YES/NO Blood disease? YES/NO Are you pregnant? YES/NO
Weakened immune system? YES/NO
Have you been vaccinated with Pneumonia Vaccine YES/NO
***El cliente tiene alguna condicion medica cronica (sin importar la edad). Tal como:*
Asma o alguno otra enfermedad pulmonary? SI/NO Enfermedad del Corazon? SI/NO
Enfermedad de los rinones? SI/NO Enfermedad de la sangre? SI/NO Esta embarazada? SI/NO
Deficiencias del sistema immunologico? SI/NO A recibido la vaccuna contra la neumonia? SI/NO

YES / SI NO 15. FOR FEMALES: Is the client pregnant or could she become pregnant in the next (1) month?
**Note: A client must NOT become pregnant within 1 month after receiving the MMR (measles, mumps, rubella) vaccine or the Varicella (Chickenpox) vaccine.
Si el cliente es una mujer – El cliente esta embarazada o podria llegar a ser embarazada en un (1) mes?
***Nota: Un cliente no debe llegar a ser embarazada dentro de un (1) mes despues de recibir la vaccuna de MMR (Sarampion, Paperas, Rebeola) ni la vaccuna de Varicela.*

***The client or the client's parent/guardian must answer ALL questions on this form before any immunizations will be given.
***El cliente o el padre/madre del cliente o custodio legal tiene que contestar TODAS las preguntas que estan en esta forma antes de recibir inmunizaciones.

CONSENT FOR IMMUNIZATIONS: I have received, read or had explained to me the vaccine information statement and I understand this information. I give permission to the Waco-McLennan County Public Health District, its staff and other health care personnel under its sponsorship, to give immunizations and/or TB skin tst to the person identified on this form. I undertand that immunizations given at school sites may be given without me being present.

CONSENTIMIENTO PARA INMUNIZACIONES: E recibido, loido/o explicado la informacion y si entiendo esta informacion. Le doy permiso al personal de esta institucion para que se le administren vacunas o la prueba de Tuberculosis a la persona nombrada en esta forma. Entiendo que las vacunas administradas en la escuela se podran dar sin que yo este presente.

Signature of CONSENTING ADULT/ Firma del adulto que da permiso: _____ Date Signed/Fecha de Firma: _____

(Check one/marca uno) ☐ Parent/ padre/madre ☐ Guardian/El guardian ☐ Other/Otro

VIS Form/s given & vaccine ADMINISTERED BY: _____ Date Signed _____

Waco-McLennan Public Health

Financial Assistance Program

Complete this form if you think you may need help with the cost of your clinic visit. Financial assistance is available for most copays, coinsurance and out-of-pocket costs.

Patient Name: _____ DOB __/__/____

Responsible Party: _____ DOB __/__/____

Do you have the following?

Health insurance? Yes* _____ No _____

Medicare, Medicaid, CHIP, Good Health Card? Yes* _____ No _____

Do you receive benefits from any of the following? (circle yes/no)

SSI	Yes	No
Disability	Yes	No
Unemployment	Yes	No
WIC	Yes	No
SNAP/TANF	Yes	No
Free/Reduced School Lunch	Yes	No

Have you filed bankruptcy in the last 12 months? Yes No

Date of Bankruptcy filing: _____

Income:

Patient Income: $_____

Weekly / Bi-Weekly / Monthly / Yearly

Household Income: $_____

Weekly / Bi-Weekly / Monthly / Yearly

Number or Persons in Household: ____

Do you have a permanent address?

Yes No

If "yes" above, do you receive subsidized housing benefits for this address?

Yes No

The above information is true, accurate and complete to the best of my knowledge. I understand that any falsification, leaving out of information and giving false information may risk my eligibility for current or future financial programs at Waco-McLennan Public Health.

Responsible Party Signature: _____

Date: 5-7-26

*If you have health coverage you must provide your insurance information and a copy of your health coverage card. You may still be eligible for participation if your insurance does not cover necessary services, or your copay/deductible is cost prohibitive.

% FPG: _____ Qualifying Program: _____	Bankruptcy: _____ Housing Qualifications: Unhoused/Subsidized	Deceased with no known estate: DOD: _____ Failed Collect: 1:_____ 2:_____ 3:_____	Approved: Yes No _____

Last Updated: 9/12/2025 CM

Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by the Waco-McLennan County Public Health District for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the Waco-McLennan County Public Health District.

I understand that diagnosis or treatment of me by the Waco-McLennan County Public Health District may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. The Waco-McLennan County Public Health District is not required to agree with the restrictions that I may request. However, if the Waco-McLennan County Public Health District agrees to a restriction that I request, the restriction is binding on the Waco-McLennan County Public Health District.

I have the right to revoke this consent, in writing, at any time, except to the extent that the Waco-McLennan County Public Health District has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by the Waco-McLennan County Public Health District staff, another health care provider or a health plan. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review the Waco-McLennan County Public Health District's Notice of Privacy Practices prior to signing this document.

I have received a copy of the Waco-McLennan County Public Health District's Notice of Privacy Practices.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Waco-McLennan County Public Health District.

The Notice of Privacy Practices for the Waco-McLennan County Public Health District is also posted in each department of the Health District and on the City of Waco's web site at www.waco-texas.com /services/health.

This Notice of Privacy Practices also describes my rights and the duties of the Waco-McLennan County Public Health District with respect to my protected health information.

The Waco-McLennan County Public Health District reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised Notice of Privacy Practices by accessing the Waco-McLennan County Public Health District's web site, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next visit.

Signature of Client or Authorized Representative	Relationship
Name of Client Date Of Birth	5-7-26 Date