WILLIAMSON COUNTY AND CITIES HEALTH DISTRICT

Immunization Clinic Register: Child

350 Discovery Blvd., Ste. 102
Cedar Park, TX 78613
Phone: 512-260-4240
Fax: 512-260-4245

100 W. 3rd St.
Georgetown, TX 78626
Phone: 512-943-3640
Fax: 512-943-5260

211 Commerce Blvd., Ste. 109
Round Rock, TX 78664
Phone: 512-248-3257
Fax: 512-248-3260

115 W. 6th St.
Taylor, TX 76574
Phone: 512-238-2121 / 512-352-4121
Fax: 512-238-2179 / 512-352-4179

Please Print

Last:____________________ First____________________ Middle Initial__________
(Name as it appears on birth certificate)

Date of Birth: ______/______/______ Sex: **Male** **Female** Country of Birth:____________________
Mo. Day Year

Race *(please circle)*: **Alaska Native** **American Indian** **Asian** **Black/African American** **Pacific Islander**

White (Non-Hispanic) **White (Hispanic)** If Hispanic, indicate origin:____________________

Address:______________________________ Apt#:______ County:____________________

City:____________________ State:______ Zip code:__________ Phone Number:____________________

Medicaid Number:____________________ Child's SS#:____________________

Mother's Maiden Name:____________________ Is Child on CHIP? **Yes / No** WIC? **Yes / No**

Who is your child's physician? ______________________________

Have you (**adult**) had a tetanus shot in the last 10 years? **Yes** **No**

I understand that as part of the provision of healthcare services, Williamson County and Cities Health District creates and maintains health records and other information describing, among other things, my health and medical history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that Williamson County and Cities Health District reserves the right to change its Notice and practices with regard to the use and disclosure of health information. I understand that I have the right to request restrictions as to how my health information may be used or disclosed for treatment, payment, or healthcare operations, but that Williamson County and Cities Health District is not required to agree to the requested restrictions.

Name of Responsible Adult:

____
Print Sign Relationship Date

Do not write below. For office use only

Date Given	VACCINE	MFG	LOT #	Route	Exp. Date	SITE(RA,LA,RT,LT)
	DTaP			IM		
	IPV			IM, SC		
	HEP B			IM		
	HIB			IM		
	KINRIX			IM		
	PEDIARIX (DTaP,HEP B, IPV)			IM		
	PENTACEL(DTaP, HIB, IPV)			IM		
	PCV13			IM		
	MENINGOCOCCAL			IM		
	MMR			SC		
	VARICELLA			SC		
	MMR/VARICELLA			SC		
	TD/TDAP			IM		
	HEP A			IM		
	ROTOVIRUS			ORAL		
	HPV			IM		
	FLU 6-35MOS			IM		
	FLU >3YRS			IM		
	FLUMIST			**Nasal**		
	H1N1			IM		
	H1N1 MIST			**Nasal**		

Nurse Signature:______________________________ **Date:**____________________