**COVID-19 Vaccine Administration Documentation**

**Section 1: Eligibility Criteria:**

As determined by current Texas DSHS Vaccine Allocation Process.

**Section 2: Patient Information: Please Print Clearly**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name: (Last)** | | | **First:** | | | | | **MI:** | **Date of Birth:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  MM/DD/YYYY | |
| **Address:** | | | | **City:** | | **State:** | **Zip:** | | **Gender:**  Male Female  No answer (NA) | **Hispanic:**  Yes  No NA |
| **County:** | **Mobile Phone #:** | **Home Phone #:** | | | **Race**: Asian American Indian/Alaska Native Black/African American  Native Hawaiian/Pacific Islander White Multiple Races  Unknown Prefer not to answer | | | | | |
| **Email:** | | | | | **Preferred Contact Language:**  English Spanish | | | | **Appointment Notification Preference**   * Email * Text | |
| **Preferred Language at Vaccination Event**  English Spanish Arabic Cantonese Chinese French German Hindi  Korean Mandarin Tagalog Urdu Vietnamese Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | **IMMTrac2 #:** | |

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**Section 3: Screening for Vaccine Eligibility:**

**For patients:** The following questions will help us determine if you are eligible to receive the COVID-19 vaccine today. If you answer “yes” to any question, it does not necessarily mean you should not be vaccinated. It just means

additional questions must be asked. If a question is not clear, please ask the nurse to explain it.

|  |  |  |  |
| --- | --- | --- | --- |
|  | YES | NO | Don’t know |
| 1.Are you feeling sick today? | □ | □ | □ |
| 2. Have you ever received a dose of the COVID-19 vaccine?  If yes, which product? \_\_\_ Pfizer \_\_\_ Moderna \_\_\_ Janssen (Johnson & Johnson)  \_\_\_ Another Product: \_\_\_\_\_\_\_\_\_\_\_\_ Verify date: \_\_\_\_\_\_\_\_\_\_   * Did you bring your vaccination record card or other documentation? (*yes/no*) | □  □ | □  □ | □ |
| 3. Have you ever had an allergic reaction to:  (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.) |  |  |  |
| • A component of a COVID-19 vaccine, including either of the following: |  |  |  |
| * Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures | □ | □ | □ |
| * Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids. | □ | □ | □ |
| • A previous dose of COVID-19 vaccine | □ | □ | □ |
| 4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?  (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.) | □ | □ | □ |
| 5. Check all that apply to you: | | | |
| □ Am a female between ages 18 and 48 years old | | | |
| □ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies | | | |
| □ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum | | | |
| □ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection | | | |
| □ Have a weakened immune system (i.e., HIV infection, cancer) | | | |
| □ Take immunosuppressive drugs or therapies | | | |
| □ Have a bleeding disorder | | | |
| □ Take a blood thinner | | | |
| □ Have a history of heparin-induced thrombocytopenia (HIT) | | | |
| □ Am currently pregnant or breastfeeding | | | |
| □ Have received dermal fillers | | | |

**Section 4: Acknowledgment/Consent:**

**ACKNOWLEDGMENT/CONSENT FOR COVID-19 VACCINATION:**

I understand that the COVID-19 vaccine is approved by the FDA under an Emergency Use Authorization. I have read or had explained to me the most recent Fact Sheet for Recipients and Caregivers or Vaccine Information Sheet for the COVID-19 vaccine being administered and understand the risks and benefits of vaccination.

I **ACKNOWLEDGE** that I have reviewed a copy of the Texas Department of State Health Services Notice of Privacy Practices.

I **GIVE CONSENT** to the Texas Department of State Health Services and its staff for the person named on this form to be vaccinated with the following vaccine: **COVID-19 vaccine**

**NOTE:** By signing this form, I hereby attest that the above information is true and correct.

**Signature of Patient/Legal Guardian:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Person Authorized to Consent** (*if not patient*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**~~~~~~~FOR OFFICE USE ONLY~~~~~~~~~~~~~**

**Section 5: COVID-19 Vaccine Immunization Documentation:**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date/Time** | **Vaccine** | **Mfg.** | **Lot No** | **Exp. Date** | **Site Given** | **Given by** | **Date VIS or Fact Sheet Given** | **VIS or Fact Sheet Date** |
|  | **COVID-19** |  |  |  |  |  |  |  |

**Nurse’s/Clinician’s signature and credentials:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature above indicates immunization given according to most current SDOs) **DSHS Field Office Stamp**

**Interpreter (if used):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 6: Additional Clinician Documentation (if needed):**

Observation Time 15 min 30 min

|  |  |
| --- | --- |
| **Date** | **Clinician Notes** |
|  |  |
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