**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 FemaleNo 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:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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** |
|  |  |
|  |  |
|  |  |