Texas Department of State Health Services

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/ County/ State	ZIP:	Phone #:	Gender: ☐ Male ☐ Female	Hispanic: ☐ Yes ☐ No
Mother's First/Maiden Name	Okay to Text: ☐ Yes ☐ No	Race: White ☐ Black ☐ Asian ☐ Alaskan ☐ American Indian ☐ Pacific Islander ☐ Other_______			

ImmTrac 2, the Texas immunization registry, has been designated as the disaster-related reporting & tracking system for immunizations in response to a disaster or public health emergency. From the time the event is declared over, ImmTrac will retain disaster related information for a period of 5 years. At the end of the 5 years, client specific information will be removed unless consent grants otherwise. I understand that DSHS will include this information in the central immunization registry. Once in ImmTrac, my disaster related information may by law be accessed by a state agency for purpose of aiding & coordinating communicable disaster prevention & control efforts and/or a provider legally authorized to administer immunizations, antivirals, and other medication for client treatment. By my signature below, I grant consent to retain my disaster related information in the Texas immunization registry beyond the 5 year period.

Client Print Name: ______________________ Client Signature: ______________________ Date: __________

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	unknown
1.Are you feeling sick today?	☐	☐	☐
2. Have you ever received a dose of the COVID-19 vaccine? If yes, which product? ___ Pfizer ___ Moderna ___ Other: __________ Verify date: __________	☐	☐	☐
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 the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures	☐	☐	☐
• Polysorbate	☐	☐	☐
• 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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)	☐	☐	☐
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.	☐	☐	☐

(Please continue to the back to complete the screening and Vaccine Consent form.)

	YES	NO	unknown
6. Have you received any vaccine in the last 14 days?	☐	☐	☐
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	☐	☐	☐
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐	☐	☐
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐	☐	☐
10. Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐	☐
11. Are you pregnant or breastfeeding?	☐	☐	☐

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 received 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	Vaccine	Mfg.	Lot No	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

Date: ____________________

Interpreter: ____________________

Section 6: Additional Clinician Documentation (if needed):

Date	Clinician Notes

Not Valid Unless Signed, Stamped & Dated