



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: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> No answer (NA)
						Hispanic: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
County:	Mobile Phone #:	Home Phone #:	Race: <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Multiple Races <input type="checkbox"/> Unknown <input type="checkbox"/> Prefer not to answer			
Email:			Preferred Contact Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish		Appointment Notification Preference <input type="checkbox"/> Email <input type="checkbox"/> Text	
Preferred Language at Vaccination Event <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Arabic <input type="checkbox"/> Cantonese <input type="checkbox"/> Chinese <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Hindi <input type="checkbox"/> Korean <input type="checkbox"/> Mandarin <input type="checkbox"/> Tagalog <input type="checkbox"/> Urdu <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other: _____						IMMTrac2 #:

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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Did you bring your vaccination record card or other documentation? (yes/no)	<input type="checkbox"/>	<input type="checkbox"/>	
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
○ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• A previous dose of COVID-19 vaccine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

5. Check all that apply to you:

- Am a female between ages 18 and 48 years old
- Am a male between ages 12 and 29 years old
- Have a history of myocarditis or pericarditis
- 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