Clear Form

TEXAS Health and Human Services | 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:**		**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 #:**	

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.)	☐	☐	☐

(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
☐ 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)

Interpreter (if used): _____

DSHS Field Office Stamp

Texas Department of State Health Services
7430 Louis Pasteur Dr.
San Antonio, TX 78229

Section 6: Additional Clinician Documentation (if needed):

Time of administration: _____

Observation Time ☐ 15 min ☐ 30 min

Date	Clinician Notes