

**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:**YesNo NA |
| **County:** | **Mobile Phone #:** | **Home Phone #:** | **Race**: Asian American Indian/Alaska Native Black/African American Native Hawaiian/Pacific Islander White Multiple RacesUnknown 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? | □ | □ | □ |
| 1. Have you ever received a dose of the COVID-19 vaccine?

If yes, which vaccine product did you receive and how many doses? Pfizer \_Moderna Janssen (Johnson & Johnson) \_\_\_\_Another Product: How many doses of COVID-19 vaccine have you received? * + Did you bring your vaccination record card or other documentation? (*yes/no*)
 | □□ | □□ | □ |
| 1. Do you have a health condition or undergoing treatment that makes you moderately or severely immunocompromised? (This would include treatment for cancer or HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematocrit therapy [HCT], DiGeorge syndrome or Wiskott-Aldrich syndrome)
 | □ | □ | □ |
| 1. Have you received hematopoietic cell transplant (HCT) or CAR-T-cell therapies since receiving COVID-19 vaccine?
 | □ | □ | □ |
| 1. 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:
 |  |  |  |
| o Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures  | □ | □ | □ |
| o Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids. | □ | □ | □ |
| * A previous dose of COVID-19 vaccine
 | □ | □ | □ |
| 1. 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.) | □ | □ | □ |
| 8. Check all that apply to you: |
| **□** Am a female between ages 18 and 49 years old |
| **□** Am a male between ages 12 and 29 years old |
| **□** Have a history of myocarditis or pericarditis |
| **□** Have been treated with monoclonal antibodies or convalescent serum to prevent or treat COVID-19 |
| **□** 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) or 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 |
| **□** History of Guillain-Barré Syndrome (GBS) |

# Section 4: Acknowledgment/Consent:

## ACKNOWLEDGMENT/CONSENT FOR COVID-19 VACCINATION:

I understand that, at this time, the COVID-19 vaccines are approved by the FDA under an Emergency Use Authorization, and only the COMIRNATY COVID-19 vaccine is FDA-approved. 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 **GRANT consent** to retain my disaster-related information (or my child’s information, if younger than age 18) in the Texas Immunization Registry beyond the 5 year retention period.

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** | **Dose** **(Circle one:)** | **DosageAmount** | **Date VIS or Fact****Sheet Given** | **VIS or Fact****Sheet Date** |
|  | **COVID-19** |  |  |  |  | **Primary Additional** **Booster** |  |  |  |

## 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 End Time:

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

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