☐ Dose 1 ☐ Dose 2

TEXAS Health and Human Services | Texas Department of State Health Services

Texas Department of State Health Services (DSHS)
COVID-19 Client Vaccination Form

Section I. Personal Information

Last Name Apellido	**First Name** Primer Nombre	**Middle Initial** Inicial Media

Home Address (Street Address) Domicilio	(City) Ciudad	(State) Estado	(Zip Code) Código Postal	(County) Condado

Mailing (if different from residence) (Street Address/P.O. Box) Correo (si es diferente de la residencia) (Dirección postal/Caja postal)	(City) Ciudad	(State) Estado	(Zip Code) Código Postal	(County) Condado

Home Telephone Teléfono de Casa	**FAX** Fax	**Mobile/Cell** Celular Móvil	**E-Mail Address** Correo Electrónico
( )	( )	( )	

Race/Ethnicity (check one)

☐ American Indian/Alaska Indio Americano/Alaska
☐ Asian Asiático
☐ Black/African American Negro/Afroamericano
☐ White ☐ Blanco
☐ Native Hawaiian/Other Pacific Islander Nativo Hawaiano/Otro Isleño del Pacífico
☐ Other (specify) Otro (Especificar) _____
☐ Not Hispanic/Latino No Hispano/Latino
☐ Hispanic/Latino Hispano/Latino

Gender Género	**Date of Birth** (MO/DY/YR) Fecha de Nacimiento	**Do you have an underlying health condition?** ¿Tiene una condición de salud subyacente?	**Job Profession/Occupation** Título Profesional/Ocupación laboral
☐ Female Mujer ☐ Male Masculino	__ __/__ __/__ __	☐ Yes Sí ☐ No No	_____

For completion by Medical Personnel (Para completar por Personal Médico)

Section II. COVID-19 Vaccine Information

Manufacturer:	☐ **Pfizer** ☐ **Moderna** ☐ **Janssen (Johnson & Johnson)** ☐ **Other: _____**	**Date Given:**	
Site of Injection:	☐ **Right Deltoid** ☐ **Left Deltoid**	**LOT #:**	
VFS Date:	☐ **Pfizer: 05/10/2021** ☐ **Moderna: 12/21/2020** ☐ **Janssen (Johnson & Johnson): 02/27/2021** ☐ **Other: _____: Date:_____**	**Date VFS Given:**	
Administrator Signature/Title:			

Section III.

Client Response to Injection:				
Is 2nd dose needed:	**YES**	**NO**	**If YES, when:**	
Vaccination Card and copies of Privacy Notice, Fact Sheet, and V-Safe information sheet were given to client:			**YES**	**NO**

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COVID-19 Client Vaccination Form

Last Name Apellido	First Name Primer Nombre	Middle Initial Inicial Media

Gender Género	Date of Birth (MO/DY/YR) Fecha de Nacimiento	Do you have an underlying health condition? ¿Tiene una condición de salud subyacente?	Job Profession/Occupation Título Profesional/Ocupación laboral
☐ Female ☐ Male Mujer Masculino	__ __/__ __/__ __	☐ Yes ☐ No Sí No	_____

COVID-19 Dose Two

Section IV. Dose 1 Review

Has there been any changes to your personal information? ¿Ha habido cambios en su información personal?		☐ **Yes** Sí ☐ **No** No	**If yes, please describe.** Si es un sí, describa.	
Dose #1 Dosis #1	**Did you have any side effects with the first dose injection?** ¿Tuvo algún efecto secundario con la inyección de la primer dosis?	☐ **Yes** Sí ☐ **No** No	**If yes, please describe.** Si es un sí, describa.	**How long did it last?** ¿Cuánto duró?

For completion by Medical Personnel (Para completar por Personal Médico)

Section V. COVID-19 Vaccine Information

Manufacturer:	☐ **Pfizer** ☐ **Moderna** ☐ **Janssen (Johnson & Johnson)** ☐ **Other:** _____	**Date Given:**	
Site of Injection:	☐ **Right Deltoid** ☐ **Left Deltoid**	**LOT #:**	
VFS Date:	☐ **Pfizer: 05/10/2021** ☐ **Moderna: 12/21/2020** ☐ **Janssen (Johnson & Johnson): 02/27/2021** ☐ **Other** _____**: Date:** _____	**Date VFS Given:**	
Administrator Signature/Title:			

Section VI.

Client Response to Injection:	
COVID-19 Vaccine Multi-Dose Complete:	☐ **Yes** ☐ **No**