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

PHR 9/10	
☐ Dose 1	☐ Dose 2
☐ Dose 3 IC	☐ Booster
☐ Pediatric Dose (5-11 yrs)	

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 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*)	☐	☐	
3. Check all that apply: ☐ I live in a long-term care setting. ☐ I have been diagnosed with a medical condition(s). Please list: _____ ☐ I am a first responder. ☐ I work in a long-term care facility, correctional facility, hospital, restaurant, retail setting, school, or other setting with high exposure to the public.			
4. 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)	☐	☐	☐
5. Have you received hematopoietic cell transplant (HCT) or CAR-T-cell therapies since receiving COVID-19 vaccine?	☐	☐	☐
6. 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 occurredwithin 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	☐	☐	☐
7. 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 **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:)	Dosage Amount	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: