☐ Dose 1 ☐ Dose 2

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 Residente ( )	**FAX** Residente ( )	**Mobile/Cell** Celular ( )	**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
☐ Female Mujer ☐ Male Masculino

Date of Birth (MO/DY/YR) Fecha de Nacimiento ____ ____ / ____ ____ / ____ ____

Section II. Insurance Information
Información del seguro

☐ **No Health Insurance** No seguro médico

Insurance Name: Nombre del Seguro:		**Group #:** Número de grupo:	
Member Name: Nombre del miembro:		**Member #:** Número de miembro:	
Member Employer: Empleador Miembro:		**Member DOB:** Fecha de nacimiento del miembro	
Member last 4 digits of SSN: Últimos 4 dígitos seguro social:		**Relationship to Member:** Relación con el Miembro:	

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

Section III. COVID-19 Vaccine Information

Manufacturer:	**Moderna**	**Date Given:**	
Site of Injection:		**LOT #:**	
VFS Date:	**12/21/2020**	**Date VFS Given:**	
Administrator Signature/Title:			

Section IV.

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**

Last Name	First Name	Middle Name/Initial	DOB ______ /______/_____

COVID-19 Dose Two

SECTION V. DOSE 1 REVIEW

	Has there been any changes to your personal information?	❒ Yes ❒ No	If yes, please describe.	
Dose #1	Did you have any side effects with the first dose injection?	❒ Yes ❒ No	If yes, please describe:	How long did it last?

Section VI. COVID-19 Vaccine Information

MANUFACTURER:	MODERNA	DATE GIVEN:	
Site of Injection:		LOT #:	
VFS Date:	12/21/2020	Date VFS Given:	
Administrator Signature/Title:			

Section VII.

Client Response to Injection:	
Covid-19 Vaccine Multi-Dose Complete	❒ YES ❒ NO