COVID-19 Vaccine Administration Documentation

Section 1: Eligibility Criteria:

As determined by current Vaccine Allocation Process.

Section 2: Patient Information: Please Print Clearly

Name: (Last)	**First:**	**MI:**	**Date of Birth:** MM/DD/YYYY
Address:	City / State **ZIP:**	**Phone #:**	**Hispanic:** ☐ Yes ☐ No
Mother's First/Maiden Name	**Okay to Text:** ☐ **Yes** ☐ **No**	**Race**: White ☐ Black ☐ Asian ☐ Alaskan ☐ American Indian ☐ Pacific Islander ☐ Other_____	

ImmTrac 2, the Texas immunization registry, has been designated as the disaster-related reporting & tracking system for immunizations in response to a disaster or public health emergency. From the time the event is declared over, ImmTrac will retain disaster related information for a period of 5 years. At the end of the 5 years, client specific information will be removed unless consent grants otherwise. I understand that DSHS will include this information in the central immunization registry. Once in ImmTrac, my disaster related information may by law be accessed by a state agency for purpose of aiding & coordinating communicable disaster prevention & control efforts and/or a provider legally authorized to administer immunizations, antivirals, and other medication for client treatment. By my signature below, I grant consent to retain my disaster related information in the Texas immunization registry beyond the 5 year period.

Client Print Name: _____ Client Signature: _____ Date: _____

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**	**unknown**
1.Are you feeling sick today?	☐	☐	☐
2. Have you ever received a dose of the COVID-19 vaccine? If yes, which product? ___ Pfizer ___ Moderna ___ Other: _____ Verify date: _____	☐	☐	☐
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 the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures	☐	☐	☐
• Polysorbate	☐	☐	☐
• 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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)	☐	☐	☐
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.	☐	☐	☐

(Please continue to the back to complete the screening and Vaccine Consent form.)

	YES	NO	unknown
6. Have you received any vaccine in the last 14 days?	☐	☐	☐
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	☐	☐	☐
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐	☐	☐
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐	☐	☐
10. Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐	☐
11. Are you pregnant or breastfeeding?	☐	☐	☐

Section 4: Acknowledgment/Consent:

oI understand the benefits and risks of the COVID-19 vaccine as described in the Emergency Use Authorization (EUA) Fact Sheet, a copy of which I was provided with this Consent Form. I have had a chance to ask questions that were answered to my satisfaction. I request the vaccine to be given to me or to the person named above, a minor for whom I represent that I am authorized to sign this Consent Form. I fully release and discharge POPULAR Pharmacy, its affiliates, their officers, directors and employees from any liability for illness, injury, loss or damage which may result there from

oI understand that at this time, the COVID-19 vaccine requires 2 doses given 21-28 days apart depending on the manufacturer. If this is my first dose of the COVID-19 vaccine, I intend to receive a second dose of the same vaccine in accordance with the timeframe specified in the Fact Sheet to complete the vaccination series.

oI agree to stay in the vaccine administration area for fifteen (15) minutes or longer if indicated by the vaccine administrator after receiving my vaccine to ensure that no immediate adverse reactions occur.

oI understand that I will be receiving the vaccination at no cost to me.

oIf insured, please bring in your prescription and medical insurance cards for your vaccine appointment. I authorize the pharmacy to bill my insurance on my behalf for the immunization – understanding I will not incur any costs.
If uninsured, you must check the box below to attest that the following information is true and accurate:
oI do not have any insurance, including but not limited to, Medicare, Medicaid, or any other private or government-funded benefit plan.

Signature of Patient/Legal Guardian: _____**Date:** _____

Person Authorized to Consent (*if not patient*): _____**Relationship:** _____

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Section 5: COVID-19 Vaccine Immunization Documentation:

Date	Vaccine	Mfg.	Lot No	Site Given	Given by	Date VIS or Fact Sheet Given	VIS or Fact Sheet Date
04/28/21	**COVID-19**	PFIZER			POPULAR PHARAMCY	04/28/21	

Clinician's signature and credentials:_____

(Signature above indicates immunization given according to most current SDOs)

Date: 04/28/2021

Interpreter: _____

Section 6: Additional Clinician Documentation (if needed):

Date	Clinician Notes