north texas area community health centers

COVID-19 VACCINE CONSENT FORM

PATIENT'S INFORMATION (PLEASE CLEARLY PRINT)

Last Name:	First Name:	Middle Name:	Date of Birth: ____/_____/_____ (Month/Date/Year)

Address:	City:	State:	Zip Code:	County:

Race:	Hispanic/ Latino Y N	Sex: M F	Age:	Phone:	Email:

Do you have insurance? ☐Yes ☐No	Subscriber/Member ID:	Subscriber Date of Birth:	Insurance Company:

If no insurance, provide the following: Driver License # State of Issue:

Emergency Contact Name:	Emergency Contact Phone:

COVID-19 VACCINATION INFORMATION

The **Johnson & Johnson, Pfizer, & Moderna** COVID-19 vaccines have been authorized by the Food and Drug Administration under an Emergency Use Authorization, or EUA, based on advice from the Secretary of Health and Human Services in response to the ongoing COVID-19 Pandemic. The COVID-19 vaccine has not been fully approved but is being made available under an EUA due to scientific evidence supporting the safety and efficacy of the COVID-19 vaccine and the vaccine's highly favorable risk-benefit ratio.

North Texas Area Community Health Centers is authorized to administer COVID-19 Vaccines based on guidance developed by the Centers for Disease Control and Prevention. In order to optimize vaccine response, you will receive **1 dose (Johnson & Johnson)** or **2 doses separated by a number of days (Pfizer- 21 days, Moderna- 28 days)**. Side effects reported in clinical trial of this vaccine include, but may not be limited to, injection site pain, redness, or swelling, fatigue, headache, muscle pain, chills, fever, joint pain, nausea, or lymph node swelling. Such symptoms normally resolve within 24 hours and are typically mild but if severe should be reported to your primary care provider.

If severe allergic symptoms develop (trouble breathing, chest pain, fast heartbeat dizziness, weakness, facial, tongue, or throat swelling, or rash) after your observation period is complete, please call 911 or proceed to the nearest Hospital Emergency Department.

SCREENING CHECKLIST FOR TODAY'S IMMUNIZATION

1	Are you sick today?	Yes No
2	Have you received any vaccinations in the last 14 days, or have you received any other COVID-19 vaccine previously that is NOT Johnson & Johnson, Pfizer nor Moderna?	Yes No
3	Have you been diagnosed with the COVID-19 infection or received treatment with monoclonal antibodies/convalescent serum for COVID-19 infection within the last 90 days?	Yes No
4	Have you ever had an allergic reaction to any COVID-19 vaccine components (listed below) or a previous dose of COVID-19 vaccine? • Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures • Polysorbate	Yes No

If you answered "Yes" to questions 1-4, we would advise you to postpone vaccination for COVID-19 as follows:

- If sick, wait until your symptoms have resolved. If you are COVID+ or have received monoclonal antibodies or convalescent serum as treatment for COVID-19, wait until 90 days have passed since positive COVID-19 test.
- Wait 2 weeks after other vaccinations to receive COVID-19 vaccination.
- If you begin a two-dose vaccine, the FIRST *AND* SECOND DOSES MUST BE FROM THE SAME MANUFACTURER- you *cannot* mix Pfizer with Moderna. Johnson & Johnson is a one dose vaccine that CANNOT be mixed with Pfizer or Moderna.
- Based on current guidance from the CDC, if you have a history of anaphylaxis (severe allergic reaction) to any ingredient in these vaccines, you *CANNOT* receive any of them.

5	Have you ever had a severe allergic reaction (anaphylactic) to a vaccine (including trouble breathing, hives, facial or tongue swelling, low blood pressure, fast heart rate) or other severe reaction to a vaccination?	Yes No
6	Do you have a history of severe allergic reaction to anything besides a vaccine, including other medications, insect stings, or bites?	Yes No
7	Do you take blood thinner or do you have a bleeding disorder?	Yes No

If you answered "Yes" to questions 5, 6, or 7, please notify the staff so that we can make the accommodations necessary to observe you more carefully following your vaccination, and if you have a bleeding tendency or are on blood thinners, we will watch you carefully for possible injection site bleeding.

8	Do you have a weakened immune system?	Yes No
9	Are you now pregnant or might become pregnant in the next 4 weeks, or are you breastfeeding?	Yes No

If you answered "Yes" to questions 8 or 9, you can choose to be vaccinated but safety and efficacy data is still being collected for people in these groups.

CONSENT FOR VACCINATION AND BILLING INSURANCE

I have been provided with and have read the EUA Fact Sheet for the COVID-19 vaccine, the COVID-19 Vaccine Consent Form, and any additional information provided. I have had the opportunity for my questions to be answered by a medical professional, and I understand that a series of two vaccines will be required. I understand the known risks and benefits of vaccination and understand that not all risks may have yet been established. I know that I am consenting to this vaccine series under an EUA in response to the COVID-19 Pandemic. I request to proceed with vaccination.

I understand North Texas Area Community Health Centers will use the information gathered to submit a claim to my insurance company for only the administration of the vaccine. I agree to remain on site for 15 minutes after vaccination and that my condition may warrant post vaccination observation for at least 30 minutes.

Date:	**Time:**	**Relationship to Patient:**
Print Name		**Signature**

Vaccine	Vaccine Info	Site	Manufacturer	Lot #	Expiration Date
COVID-19 Vaccine	**Series** 1st 2nd	Deltoid: Left Right	J&J Pfizer Moderna		

Vaccine Administrator & Credentials Print	Sign	**Date Administered**	**Location** **Arlington NS SE**

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

ImmTrac2 Immunization Registry
DISASTER INFORMATION RETENTION CONSENT FORM

(Please print clearly)

Client's Last Name

Client's First Name

Client's Middle Name

Client's Date of Birth (__/__/____)

*A parent, legal guardian or managing conservator must sign this form if the client is younger than 18 years of age.

Client's Gender: ☐ Male ☐ Female

Client's Address

Apartment #

Client's Telephone (___-___-____)

City

State

Zip Code

County

Mother's First Name (if client is younger than 18 years of age)

Mother's Maiden Name (if client is younger than 18 years of age)

ImmTrac2, the Texas immunization registry, has been designated as the disaster-related reporting and tracking system for immunizations, antivirals, and other medications administered to individuals in preparation for, or in response to, a disaster or public health emergency. From the time the event is declared over, ImmTrac2 will retain disaster-related information received from health-care providers for a period of 5 years. At the end of the 5 year retention period, client-specific disaster-related information will be removed from the Registry unless consent is granted to retain the client information in ImmTrac2 beyond the 5 year retention period.

The Texas Department of State Health Services (DSHS) encourages your voluntary participation in the Texas immunization registry.

Consent for Retention of Disaster-Related Information and Release of Information to Authorized Entities

I understand that, by granting the consent below, I am authorizing retention of my (or my child's) disaster-related information by DSHS beyond the 5 year retention period. I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac2"). Once in ImmTrac2, my (or my child's) disaster-related information may by law be accessed by:

- a state agency, for the purpose of aiding and coordinating communicable disease prevention and control efforts, and / or
- a physician or other health-care provider legally authorized to administer immunizations, antivirals, and other medications, for treating the client as a patient;

I understand that I may withdraw this consent to retain information in the ImmTrac2 Registry beyond the 5 year retention period and my consent to release information from the Registry, at any time by written communication to the Texas Department of State Health Services, ImmTrac2 Group – MC 1946, P. O. Box 149347, Austin, Texas 78714-9347.

By my signature below, 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.

Client (or parent, legal guardian, or managing conservator): _____

Printed Name:

Date:_____ Signature: _____

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.texas.gov for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Upon completion, please fax or mail form to the DSHS ImmTrac2 Group or a registered Health-care provider.

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com • ImmTrac2 DC

Texas Department of State Health Services • ImmTrac2 Group – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

PROVIDERS REGISTERED WITH ImmTrac2

Please enter client information in ImmTrac2 and **affirm** that consent has been granted.

DO NOT fax to ImmTrac2. **Retain this form in your client's record.**