Community Health Centers of South Central Texas, Inc.

COVID-19 Vaccine Acknowledgement & Consent Form

Please Check One: ❒ **J&J/Janssen One Dose** ❒ **Moderna 1st Dose** ❒ **Moderna 2nd Dose**		
Last:	**First:**	**Phone:**
Home Address:	**City/State/Zip:**	
Date of Birth:	**Marital Status:** ❒ Single ❒ Married ❒ Divorced ❒ Separated ❒ Widow	**Sex:** ❒ Male ❒ Female ❒ Other
Race:(check all that apply): ❒ Black ❒ White ❒ Asian ❒ American Indian/Alaska Native ❒ Native Hawaiian/Other Pacific Islander ❒ Other, specify: _____		**Ethnicity:** ❒ Hispanic/Latino ❒ Non-Hispanic/Latino
Social Security Number:	**Driver's License/ID Number:**	
Employment Status:	**Employer (if applicable):**	

INSURANCE INFORMATION		
Primary Insurance Company Name:	**Policy Number:**	**Group Number:**
Policy Holder Name:	**Date of Birth**	**Social Security Number:**

PLEASE ANSWER THE FOLLOWING QUESTIONS AND CHECK FOR APPROPRIATE COLUMN	**Yes**	**No**
Are you feeling sick today?		
Have you ever received a dose of COVID-19 vaccine? If yes, which vaccine product? ❒ Pfizer ❒ Moderna ❒ Another Product:		
Have you ever had a severe allergic reaction to something? For example, a reaction for which you were treated with epinephrine or EpiPen® or for which you had to go to the hospital?		
Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?		
Have you received passive antibody therapy as a treatment for COVID-19?		
Do you have a weakened immune system or on a medication that affects your immune system?		
Have you received any another vaccine in the past 14 days?		
FEMALE PATIENTS ONLY		
Are you pregnant or planning to become pregnant?		
Are you breastfeeding?		

I consent to administration of the COVID-19 vaccination and acknowledge and agree with the following statements:

- I have received the Emergency Use Authorization (EUA) Fact Sheet for Recipients and Caregivers for the COVID-19 Vaccine (the "Fact Sheet")
- I have read the Fact Sheet or had it read to me.
- The U.S. Food and Drug Administration (FDA) has authorized emergency use of the COVID-19 vaccine, which is not an FDA-approved vaccine. At this time, there is no FDA approved vaccine to prevent COVID-19.
- I understand the known and potential risks and benefits to the COVID-19 vaccine and the extent to which such benefits and risks are unknown.

Community Health Centers of South Central Texas, Inc.
COVID-19 Vaccine Acknowledgement & Consent Form

- I acknowledge that I have the option to refuse vaccination and have been informed of any available alternatives to the COVID-19 vaccine and the risks and benefits of available alternatives.
- Recipients who are Pregnant or Breastfeeding: Pregnant and breastfeeding persons were not included in the clinical trials for the COVID-19 vaccine. I have discussed the potential risks of COVID-19 infection versus the risk of vaccination with my healthcare provider and have made the informed decision to receive the COVID-19 vaccine.
- I understand that it is recommended that I remain at the vaccination clinic for fifteen (15) minutes following administration of the vaccine for observation (the "Monitoring Period") to ensure I do not experience an adverse reaction and to treat adverse reactions that may ensue. Recipients that have a history of anaphylaxis should be monitored for thirty (30) minutes post vaccine.
- I have had the opportunity to ask questions which have been answered to my satisfaction.

If you experience an adverse reaction to the COVID-19 vaccine, please contact your primary care provider or present to the nearest emergency department. If you are experiencing a medical emergency, call 911.

Signature of Recipient/Authorized Representative :	**Date:**

Print:

If signed by Authorized Representative, please state relationship to Recipient:

For clinical use only. Do not write below this line.

Manufacturer		**Lot Number:**
Injection Site		**Expiration Date:**
Right Deltoid	◯	
Left Deltoid	◯	

Vaccine Administrator Print Name:	**Date:**	**RN**	**LVN**	**MA**	**MD**
		◯	◯	◯	◯

Vaccine Administration Location:

□ GCHC □ LCHC □ SFHC □ VCHC □ BCHC □ BISD □ FHCE □ LKFP

❒ Monitoring period completed and no adverse reaction noted.
❒ Recipient declined Monitoring period. Waiver completed.

Signature of Observer: _____

❒ COVID-19 Acknowledgement and Consent form and Monitoring Period Waiver (if applicable) emailed to QI@chcsct.com (for recipients who are CHCSCT employees only)

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

TEXAS IMMUNIZATION REGISTRY (ImmTrac2)
ADULT CONSENT FORM

(Please print clearly)

First Name _____ Middle Name _____ Last Name _____

Date of Birth (mm/dd/yyyy) ____/____/____ Gender: ☐ Female ☐ Male Telephone ____-____-____ Email address _____

Address _____ Apartment # / Building #

City _____ State _____ Zip Code _____ County _____

Mother's First Name _____ Mother's Maiden Name _____

Race (select all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race
☐ Recipient Refused

Ethnicity (select only one)

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Recipient Refused

The Texas Immunization Registry is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates immunization records for public health purposes (e.g., giving all doctors treating a patient a central place to see that patient's immunization records). With your consent, your immunization information will be included in ImmTrac2.

For a family member younger than 18 years of age, a parent, legal guardian, or managing conservator may grant consent for participation for that minor by completing the ImmTrac2 Minor Consent Form (# C-7) available for downloading at www.ImmTrac.com.

Consent for Registration and Release of Immunization Records to Authorized Persons / Entities

I understand that, by granting the consent below, I am authorizing release of my immunization information to DSHS and I further understand that DSHS will include this information in the Texas Immunization Registry. Once in ImmTrac2, my immunization information may by law be accessed by: a Texas physician, or other health care provider legally authorized to administer vaccines, for treatment of the individual as a patient; a Texas school in which the individual is enrolled; a Texas public health district or local health department, for public health purposes within their areas of jurisdiction; a state agency having legal custody of the individual; a payor, currently authorized by the Texas Department of Insurance to operate in Texas for immunization records relating to the specific individual covered under the payor's policy. **I understand that I may withdraw this consent at any time.**

State law permits the inclusion of immunization records for First Responders and their immediate family members (older than 18 years of age) in the Registry. A "First Responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency. An "immediate family member" is defined as a parent, spouse, child, or sibling who resides in the same household as the First Responder. For a family member younger than 18 years of age, a parent, legal guardian, or managing conservator may grant consent for participation as an "ImmTrac2 child" by completing the Immunization Registry (ImmTrac2) Consent Form (# C-7).

Please mark the appropriate box to indicate whether you are a First Responder or an Immediate Family Member.

☐ I am a FIRST RESPONDER. ☐ I am an IMMEDIATE FAMILY MEMBER (older than 18 years of age) of a First Responder.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my information in the Texas immunization registry.

Individual (or individual's legally authorized representative): _____ 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)

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

Texas Department of State Health Services • ImmTrac 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.**