Vaccine Screening and Consent Form

Recipient First Name:	Recipient Last Name:	Date of Birth (mm/dd/yyyy) ___/____/_____

Consenter's Name (if applicable):

If the person completing this form is a consenter for a child and is not a parent, guardian or managing conservator, please list the names of the parent(s), guardian or managing conservator:

Consenter's Relationship to Child

- ☐ a parent or guardian of the child;
- ☐ a person authorized under the law of another state or a court order to consent for the child;
- ☐ a grandparent of the child;
- ☐ an adult brother or sister of the child;
- ☐ an adult aunt or uncle of the child;
- ☐ a stepparent of the child;
- ☐ another adult who has actual care, control, and possession of the child and has written authorization to consent for the child from a parent, managing conservator, guardian, or other person who, under the law of another state or a court order, may consent for the child;
- ☐ an adult having actual care, control, and possession of the child under an order of a juvenile court or by commitment by a juvenile court to the care of an agency of the state or county; or
- ☐ an adult having actual care, control, and possession of the child as the child's primary caregiver
- ☐ **none of the above - consenter CANNOT consent for the child to receive the vaccination.**

Does the Consenter have actual knowledge that a parent, managing conservator, guardian of the child, or other person who, under the law of another state or a court order, may consent for the child:

- has expressly refused to give consent to the immunization;
- has been told not to consent for the child; or
- has withdrawn a prior written authorization for the person to consent?

☐ No ☐ Yes **IF YES, consenter CANNOT consent for the child to receive the vaccination**

The COVID-19 vaccine has 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.

Pursuant to the National Childhood Vaccine Injury Act of 1986 (42 U.S.C. Section 300aa-1 et seq.) the United States established the National Vaccine Injury Compensation Program (VICP) that allows for the recovery of unreimbursed expenses for certain injuries related to a VCIP-covered vaccine by individuals that file a petition with the U.S. Court of Federal Claims. More information about the VICP is available at https://www.hrsa.gov/vaccine-compensation/index.html and for any questions, you may call 1-800-338-2382 or email: vaccinecompensation@hrsa.gov.

CONSENT

I agree that the person named above will receive a vaccine. I understand there will be no cost to me for this vaccine. I understand that I will not be asked the immigration status of myself, or the person named above, as part of the process of receiving the vaccine. **I have received a copy of the notice of privacy practices.** I understand the risk of the disease this vaccine helps to prevent. I understand the potential side effects, risks, and benefits associated with this vaccine and that it is not possible to predict all possible side effects or complications associated with receiving this vaccine. I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration and possibly up to 30 minutes if a medical provider deems it necessary. I understand that if I or the person named above experiences a severe allergic reaction, I am advised to call 9-1-1 or seek immediate assistance from the nearest hospital. I have had a chance to ask questions about the vaccine preventable illness and the vaccine being administered. I agree to hold harmless the City of Austin, including its employees, agents, and contractors, from any liability and claims related to my receipt of this vaccine. I am an adult who can legally consent for the person named above to receive the vaccine. I freely and voluntarily give my signed consent and permission for the administration and injection of the vaccine into my person, or the person named above.

I have received a copy of the:	☐ Influenza Vaccine Information Statement (VIS)	☐ COVID-19 Vaccine Emergency Use Authorization (EUA) Fact Sheet
Printed Name:	Signature:	Date:

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VACCINE SCREENING QUESTIONS FOR RECIPIENT	YES	NO
1. Are you feeling sick today?		
2. Have you received the COVID-19 vaccine?		
3. If yes, which vaccine did you receive? Please circle one: Pfizer-BioNTech Moderna Janssen Other product: _____ How many doses have you received? 1 2 3		
4. Have you had a reaction to any COVID-19 vaccine, flu vaccine, or any other vaccine or injectable medication?		
5. Have you had a severe allergic reaction to any medication, food, pet, insect or other? If so, please list here:		

6. Check all that apply to you:
   - ☐ Have a history of myocarditis or pericarditis
   - ☐ Diagnosed with COVID-19 in the last 10 days
   - ☐ Had COVID-19 and was treated with convalescent serum or monoclonal antibodies
   - ☐ Diagnosed with Multisystem Inflammatory Syndrome after a COVID-19 infection
   - ☐ Have a bleeding disorder or history of heparin induced thrombocytopenia (HIT)
   - ☐ Taking a daily blood thinner
   - ☐ Have a weakened immune system
   - ☐ Taking immunosuppressive drugs or therapies
   - ☐ Currently pregnant or breastfeeding
   - ☐ History of Guillain-Barré Syndrome (GBS)
   - ☐ Have received dermal fillers

PLEASE ANSWER THE FOLLOWING QUESTIONS	YES	NO	PREFER NOT TO ANSWER
Do you have health insurance?			
If yes, what type? (Please circle all that apply) MAP/Clinic Card Medicaid Medicare Private None of these			
How many people live in the household?			
What is the annual household income? (Please circle one) Under $24,999 | $25,000 – 40,000 | $40,001 – 60,000 | $60,001 – 75,000 | $75,000-100,000 | $100,000 +			
Are you experiencing homelessness?			
Within the last 30 days, have you used any tobacco products or electronic cigarettes?			

CLINIC USE ONLY----- DO NOT WRITE BELOW THIS LINE

VACCINE	MANUFACTURER	LOT NUMBER	DOSAGE	SITE ADMINISTERED	DOSE (1, 2, or 3)	FACT SHEET GIVEN (Initials)
Moderna	ModernaTX			☐LD ☐RD ☐LT ☐RT		
Comirnaty	Pfizer-BioNTech			☐LD ☐RD ☐LT ☐RT		
Janssen	Janssen Biotech			☐LD ☐RD ☐LT ☐RT		
Fluzone Quad	Sanofi			☐LD ☐RD ☐LT ☐RT		
				☐LD ☐RD ☐LT ☐RT		

PROVIDER SIGNATURE AND CREDENTIALS:

DATE ADMINISTERED: CLINIC SITE:

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

Texas Immunization Registry (ImmTrac2)
Disaster Information Retention Consent Form

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

First Name _____ Middle Name _____ Last Name _____

Date of Birth (mm/dd/yyyy) ____/____/____ Gender: ☐ Male ☐ Female 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 (ImmTrac2) 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, the Texas Immunization Registry will retain disaster-related information received from health-care providers for a period of five (5) years. At the end of the five (5) year retention period, client-specific disaster-related information will be removed from the Texas Immunization Registry unless consent is granted to retain the client information in the Texas Immunization Registry beyond the five (5) year retention period. For more information, see Texas Health and Safety Code Sec. 161.00705. https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.00705.

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 five (5) year retention period. I further understand that DSHS will include this information in the Texas Immunization Registry. Once in the Texas Immunization Registry, 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 Texas Immunization Registry beyond the five (5) year retention period and my consent to release information from the Texas Immunization Registry, at any time by written communication to the Texas Department of State Health Services.

State law permits the inclusion of immunization records for First Responders and their immediate family members in the Texas Immunization 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.

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 of a First Responder.

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 _____ Signature _____ Date _____

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)

Provider Statement

PROVIDERS REGISTERED WITH the Texas Immunization Registry: Please enter client information in the Texas Immunization Registry and affirm that consent has been granted. **DO NOT** fax to the Texas Immunization Registry. **Retain this form in your client's record.**

Contact Information

Questions? Tel: (800) 348-9158 • Fax: (512) 776-7790 • www.ImmTrac.com
Texas Department of State Health Services • Immunizations • Texas Immunization Registry – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347