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

Texas Department of State Health Services (DSHS)
COVID-19 Client Vaccination Form

☐ Dose 1 ☐ Dose 2
☐ Dose 3 IC ☐ Booster
☐ Pedi (5-11 yrs.)

Section I. Personal Information Informacion Personal

Last Name Apellid	**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 de Casa	**FAX** Fax	**Mobile/Cell** Celular Móvil	**E-Mail Address** Correo Electrónico
( )	( )	( )	

Race/Ethnicity (check one) Raza / Etnicidad (marque uno)

☐ 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
☐ Hispanic/Latino Hispano/Latino
☐ **Other (specify)** Otro (Especificar) _____

Gender Género	**Date of Birth** (MO/DY/YR) Fecha de Nacimiento (MES/DIA/AÑO)	**Age Group** Grupo de Edad	**Do you have an underlying health condition?** ¿Tiene una condición de salud subyacente?
☐ Female Mujer ☐ Male Masculino	__ ____/__ __ __/__ __ __	☐ 5 -11 ☐ 12-15 ☐ 16-17 ☐ 18-49 ☐ 50-64 ☐ 65+	☐ Yes Sí ☐ No No

FOR COMPLETION BY MEDICAL PERSONNEL (PARA COMPLETAR POR PERSONAL MÉDICO)

Section II. COVID-19 Vaccine Information

Dose Given:	☐ Dose 1 ☐ Dose 2 ☐ Dose 3 IC ☐ Booster	**Date Given:**	
Manufacturer:	☐ **Pfizer** ☐ **Moderna** ☐ **Janssen** (Johnson & Johnson)	**LOT #:**	
VFS Dates	☐ **Pfizer Pedi (5-11yo): 10/29/2021** ☐ **Pfizer| Comirnaty: 11/19/2021** ☐ **Moderna: 11/19/2021** ☐ **Janssen (Johnson & Johnson): 11/19/2021**	**Date VFS Given:**	

Site of Injection:	☐ Right Deltoid ☐ Left Deltoid	**Vaccine Series**	☐ Additional dose Needed ☐ Multi-Dose complete:	**Next vaccine due date**	

Vaccination Card and copies of Privacy Notice, Fact Sheet, and V-Safe information sheet were given to client	☐ **YES**	☐ **NO**

Administrator Signature/Title:	

Section III.

Client Response to Injection:	
Notes:	

Prevaccination Checklist for COVID-19 Vaccination

For vaccine recipients:

The following questions will help us determine if there is any reason you should not get 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 may be asked. If a question is not clear, please ask your healthcare provider to explain it.

Name _____

Age _____

	Yes	No	Don't know
1. Are you feeling sick today?	☐	☐	☐
2. Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product(s) did you receive? ☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen *(Johnson & Johnson)* ☐ Another Product _____			
• How many doses of COVID-19 vaccine have you received? _____			
• Did you bring your vaccination record card or other documentation?	☐	☐	
3. Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? *(This would include treatment for cancer or HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], DiGeorge syndrome or Wiskott-Aldrich syndrome)*	☐	☐	☐
4. Have you received hematopoietic cell transplant (HCT) or CAR-T-cell therapies since receiving COVID-19 vaccine?	☐	☐	☐
5. 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 caused hives, swelling, or respiratory distress, including wheezing.)*			
• A component of a COVID-19 vaccine, including either of the following:			
○ Polyethylene glycol *(PEG)*, which is found in some medications, such as laxatives and preparations for colonoscopy procedures	☐	☐	☐
○ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
6. 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 caused hives, swelling, or respiratory distress, including wheezing.)*	☐	☐	☐

7. Check all that apply to you:

- ☐ Am a female between ages 18 and 49 years old
- ☐ Am a male between ages 12 and 29 years old
- ☐ Have a history of myocarditis or pericarditis
- ☐ Have been treated with monoclonal antibodies or convalescent serum to prevent or treat COVID-19
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a bleeding disorder
- ☐ Take a blood thinner
- ☐ Have a history of heparin-induced thrombocytopenia (HIT)
- ☐ Am currently pregnant or breastfeeding
- ☐ Have received dermal fillers
- ☐ Have a history of Guillain-Barré Syndrome (GBS)

Form reviewed by _____ **Date** _____

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists