ASKE Solutions, LLC
4001 N. US Hwy 183
Lockhart, Texas 78644
512.481.2753

COVID-19 Vaccination Consent Form 2021

Last Name *(Please print)*	First Name	MI	Date of Birth	☐ Male ☐ Female

Address	City	State	Zip

County of Residence	Phone Number	Ethnicity	Race (Please Circle One)
		☐ Hispanic or Latino ☐ Not Hispanic/Latino	White African American Alaska Native Pacific Islander American Indian Native Hawaiian Other_____ _____

SCREENING FOR VACCINATION ELIGIBILITY

1. Are you pregnant?	Yes	No
2. Are you currently breastfeeding?	Yes	No
3. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to other vaccines or injectable medications/infusions?	Yes	No
4. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to any component of the vaccine, including lipid nanoparticles or polyethylene glycol (PEG)?	Yes	No
5. Have you received any other vaccine within the past 14 days or are scheduled to receive any vaccine in the next 14 days?	Yes	No
6. Have you received convalescent plasma or monoclonal/polyclonal antibody infusions for COVID-19 within the past 90 days?	Yes	No
7. Are you under age 16?	Yes	No
8. Are you currently sick? For example, are you currently experiencing fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, etc.?	Yes	No
9. Have you tested positive for COVID-19 in the last 10 days?	Yes	No
10. Are you currently in quarantine for COVID-19 exposure?	Yes	No
11. If this is your second dose, when was the date of your first dose?	/ /	
12. If this is your second dose, which vaccine did you receive (Pfizer, Moderna, etc.)?		

CONSENT FOR VACCINATION

I will/have reviewed my answers to the questions above with the vaccinator. If I experience any adverse reactions after leaving, I will notify my primary care provider. I have viewed the Emergency Use Authorization Fact Sheet provided to me today. I understand the benefits and risks of the vaccine.

The vaccine checked above should be given to the person named above for whom I am authorized to make this request. I understand that I can review a Notice of Privacy Practice at the time of vaccination.

Signature of Parent/Guardian/Patient_____ Date_____

FOR ADMINISTRATIVE USE ONLY **VIS Date:**

Vaccine	Date Vaccination and EUA Given:	Route	Manufacturer	Lot No.	Printed Name and Signature of Vaccine Administrator
		IM R - L	Moderna		

INFORMATION FOR HEALTH CARE PROFESSIONALS ABOUT VACCINATION ELIGIBILITY

1. Are you pregnant?

   IF YES: Please ask the patient whether they discussed vaccination with a medical provider. Patients who are pregnant may choose to be vaccinated whether they discussed vaccination with a medical provider or not.

2. Are you currently breastfeeding?

   IF YES: Please ask the patient whether they discussed vaccination with a medical provider. Patients who are lactating may choose to be vaccinated whether they discussed vaccination with a medical provider or not.

3. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to other vaccines or injectable medications/infusions?

   IF YES: Please ask the patient whether they discussed vaccination with a medical provider. If they have, allow vaccination to proceed. Vaccine providers should observe patients after vaccination to monitor for the occurrence of immediate adverse reactions:
   - **Persons with a history of anaphylaxis: 30 minutes**
   - **All other persons: 15 minutes**

4. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to any component of the vaccine, including lipid nanoparticles or polyethylene glycol (PEG)?

   IF YES: Do Not Vaccinate

5. Have you received any other vaccine within the past 14 days or are scheduled to receive any vaccine in the next 14 days?

   IF YES: Do Not Vaccinate

6. Have you received convalescent plasma or monoclonal/polyclonal antibody infusions for COVID-19 within the past 90 days?

   IF YES: Do Not Vaccinate

7. Are you under age 16?

   IF YES: Do Not Vaccinate

8. Are you currently sick? For example, are you currently experiencing fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, etc.?

   IF YES: Have patient discuss existing symptoms with a medical provider.

9. Have you tested positive for COVID-19 in the last 10 days?

   IF YES: Do Not Vaccinate

10. Are you currently in quarantine for COVID-19 exposure?

    IF YES: Do Not Vaccinate

11. If this is your second dose, when was the date of your first dose?

    Do Not Vaccinate if less than 17 days ago for Pfizer, or less than 24 days ago for Moderna.

12. If this is your second dose, which vaccine did you receive (Pfizer, Moderna, etc.)?

    Ensure that the second dose is from the same manufacturer as the first dose.
    If different: Do Not Vaccinate.

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) _____ ( ) Telephone _____ Email address _____ Gender: ☐ Female ☐ Male

Address _____ Apartment # / Building # _____

City _____ State _____ Zip Code _____ County _____

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

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.**

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

REGISTRO DE INMUNIZACIÓN DE TEXAS (ImmTrac2)
FORMULARIO DE CONSENTIMIENTO PARA ADULTOS

(Escriba claramente en letra de molde)

Primer Nombre _____ Segundo Nombre _____ Apellido _____

Género: ☐ Femenino ☐ Masculino

Fecha de Nacimiento (mm/dd/aaaa) _____ Teléfono _____ Correo electrónico _____

Dirección _____ Apartamento # / Edificio # _____

Ciudad _____ Estado _____ Código Postal _____ Condado _____

Nombre de la Madre _____ Apellido de soltera de la madre _____

El Registro de Inmunización de Texas es un servicio gratuito del Departamento Estatal de Servicios de Salud (DSHS) de Texas. Se trata de un servicio seguro y confidencial que consolida los registros de vacunación con fines de salud pública (por ej., para darle a cada médico que atienda a un paciente un lugar central donde pueda ver los registros de vacunas de dicho paciente). Al darnos usted su consentimiento, los datos sobre sus vacunas se incluirán en el ImmTrac2. *En el caso de un menor de 18 años de edad, uno de los padres, el tutor legal o el titular de la custodia puede dar el consentimiento para que ese menor participe. Para ello, deberá llenar el formulario de consentimiento del ImmTrac2 para menores (# C-7), que puede descargar en: www.ImmTrac.com.*

Consentimiento para el registro y para divulgar los registros de inmunización a las personas o entidades autorizadas

Entiendo que, al dar aquí mi consentimiento, autorizo la divulgación de mis datos de vacunación al DSHS, y además entiendo que el DSHS incluirá esta información en el Registro de Inmunización de Texas. Una vez que la información sobre mis vacunas esté en el ImmTrac2, las siguientes entidades tendrán por ley acceso a ella: un médico u otro proveedor de salud de Texas legalmente autorizado para administrar vacunas, con fines de tratamiento de la persona como paciente; una escuela de Texas en la que la persona esté inscrita; un distrito de salud pública o departamento de salud local de Texas, con fines de salud pública dentro de sus zonas de jurisdicción; una entidad estatal que tenga la custodia legal de la persona; un pagador actualmente autorizado por el Departamento de Seguros de Texas para operar en el estado respecto a los registros de vacunación de la persona que tenga cobertura bajo la póliza del pagador. **Entiendo que puedo revocar este consentimiento en cualquier momento.**

La ley estatal permite la inclusión en el ImmTrac2 de los registros de vacunación de los socorristas y sus familiares directos (mayores de 18 años). Se define como "socorrista" al empleado de la seguridad pública o voluntario entre cuyas funciones está responder rápidamente a una emergencia médica. Se define como "familiar directo" a los padres, el cónyuge, hijos o hermanos que viven en el mismo hogar que el del socorrista. En el caso de un familiar menor de 18 años, uno de los padres, el tutor legal o el titular de la custodia puede dar el consentimiento para que el menor participe en calidad de "menor en el ImmTrac2", llenando el formulario de consentimiento (# C-7) del Registro de Inmunización (ImmTrac).

Marque la casilla correspondiente para indicar si es usted un socorrista o un familiar directo de este.

☐ **Soy un SOCORRISTA.** ☐ **Soy FAMILIAR DIRECTO (mayor de 18 años) de un socorrista.**

Con mi firma a continuación, **DOY** mi consentimiento para el registro. Deseo **INCLUIR** mi información en el registro de vacunación de Texas.

La persona (o el representante legalmente autorizado de la persona): _____ Nombre en letra de molde

Fecha _____ Firma _____

Notificación de privacidad: con ciertas excepciones, tiene derecho a pedir y a ser informado sobre la información que el estado de Texas reúne sobre usted. Tiene derecho a recibir y examinar la información al pedirla. También tiene derecho a pedir a la agencia estatal que corrija cualquier información que se determine es incorrecta. Consulte http://www.dshs.texas.gov para obtener más información sobre la notificación de privacidad. (Referencia: Código gubernamental, sección 552.021, 552.023, 559.003 y 559.004)

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

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