



Addendum to COVID-19 Vaccine Information Statement

- 1. I agree that the person named below will get the vaccine checked below.
2. I received or was offered a copy of the Vaccine Fact Sheet for the vaccine listed above.
3. I know the risks of the disease this vaccine prevents.
4. I know the benefits and risks of the vaccine.
5. I have had a chance to ask questions about the disease the vaccine prevents, the vaccine, and how the vaccine is given.
6. I know that the person named below will have the vaccine put in his/her body to prevent the disease this vaccine prevents.
7. I am an adult who can legally consent for the person named below to get the vaccine. I freely and voluntarily give my signed permission for this vaccine.

\*STATEMENT: I authorize the release of any medical or other information necessary to process the claim. I also request payment of government benefits to the party who accepts assignment.

Provider Identification Number: \_\_\_\_\_

Medicare Health Insurance Claim Number: \_\_\_\_\_

Vaccine to be given: [ ] COVID-19 Vaccine by Moderna, [ ] COVID-19 Vaccine by Pfizer, [ ] COVID-19 Vaccine by Johnson & Johnson

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)

Privacy Notice: I acknowledge that I have received a copy of my immunization provider's HIPAA Privacy Notice.

Information about person to receive vaccine (Please print)
Name: Last First Middle Initial Birthdate (mm/dd/yy) Sex (circle one) M F
Address: Street City County State TX Zip
Signature of person to receive vaccine or person authorized to make the request (parent or guardian):
X \_\_\_\_\_ Date: \_\_\_\_\_
X \_\_\_\_\_ Date: \_\_\_\_\_
Witness
RACE White Black or African American American Indian or Alaska Native
Asian Native Hawaiian or Other Pacific Islander Other
ETHNICITY Hispanic or Latino Not Hispanic or Latino

[ ] CASH [ ] CHECK For Clinic / Office Use Only

Clinic / Office Address: Milam Co. Health Dept. 209 S Houston St. Cameron, Texas 76520 254-697-7039
Date Vaccine Administered:
Vaccine Manufacturer: Moderna / Pfizer / Johnson & Johnson
Vaccine Lot Number:
Site of Injection: RD / LD
Title of Vaccine Administrator: RN / LVN / EMT-P
Signature of Vaccine Administrator:
Date Fact Sheet Given:

Notice: Alterations or changes to this publication is prohibited without the express written consent of the Texas Department of State Health Services, Immunization Unit.

Instructions: File this consent statement in the patient's chart.

# Prevaccination Checklist for COVID-19 Vaccines



## 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 \_\_\_\_\_

1. Are you feeling sick today?

Yes	No	Don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Have you ever received a dose of COVID-19 vaccine?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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• If yes, which vaccine product did you receive?

Pfizer       Moderna       Janssen  
(Johnson & Johnson)       Another Product

<input type="checkbox"/>	<input type="checkbox"/>	
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• Did you bring your vaccination record card or other documentation? (yes/no)

3. 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

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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○ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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• A previous dose of COVID-19 vaccine

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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4. 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.)*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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5. Check all that apply to you:

- Am a female between ages 18 and 49 years old
- Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies
- Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
- Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- Have a weakened immune system (i.e., HIV infection, cancer)
- Take immunosuppressive drugs or therapies
- 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

Form reviewed by \_\_\_\_\_

Date \_\_\_\_\_