Vaccine Administration Record (VAR) ☐1st / ☐ 2nd / ☐ 3rd Dose / ☐ Booster ☐ Pediatric

First Name: _____ **Last Name:** _____

Date of Birth: _____ **Age:** _____ **Gender:** M F **Phone:** _____

Address: _____ **Email Address:** _____

City: _____ **State:** _____ **Zip Code:** _____

Eth: □ Hispanic or Latino □ Not Hispanic or Latino □ Unknown □ Unable to report due to law/policy

Race: □ American Indian or Alaska Native □ Asian □ Native Hawaiian or Other Pacific Islander □ Black or African American □ White □ Other Race □ Unknown □ Unable to report due to policy/law

How did you hear about this clinic? _____

I want to receive the following vaccination(s): **COVID-19 Vaccination** _____

I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient; or (c) a person authorized to consent on behalf of the patient where the patient is not otherwise competent or unable to consent for themselves. I give my consent to the clinic operator/provider and the licensed healthcare professional administering the vaccine, as applicable (each an "applicable Provider"), to administer the vaccine(s) I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the EUA Fact Sheet on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised that the patient should remain near the vaccination location for observation for approximately 15 minutes after administration. On behalf of the patient, the patient's heirs and personal representatives, I hereby release and hold harmless each applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above.

I further authorize the applicable Provider to: (a) submit a claim to my insurer for the above-requested items and services; and (b) request payment of authorized benefits be made on my behalf to the applicable Provider with respect to the above-requested items and services. I authorize the release of any medical information necessary to process this claim. I authorize the release of personal information to affiliates in order to contact me in the future regarding health and safety matters, such as vaccine reminders. I permit a copy of this authorization to be used in place of the original. I request that payment from my insurance company be made directly to Provider (or to the party who accepts assignment). I certify that the information that I have reported with regard to my insurance coverage is correct. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

The Provider or its affiliates may contact you, including by autodialed and pre-recorded calls and texts, at any time using the contact information provided in your patient record regarding health and safety matters, such as vaccine reminders, regardless of whether you have opted out of being contacted.

I understand that the COVID-19 vaccine is approved by the FDA under an Emergency Use Authorization. I have read or had explained to me the most recent Fact Sheet for Recipients and Caregivers or Vaccine Information Sheet for the COVID-19 vaccine being administered and understand the risks and benefits of vaccination.

I ACKNOWLEDGE that I have viewed the Provider's Notice of Privacy Practices and may receive a copy if I so request.

Note: By signing this form, I hereby attest that all information provided for the COVID-19 Vaccine Administration Documentation is true and correct.

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.

I certify that I am: (a) the patient and at least 18 years of age; or (b) the legal guardian of the patient and have sufficient knowledge of the patient's condition to answer the Screening Questions. I acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.

Print Name: _____ Patient/Authorized person signature: _____ Date: _____

SECTION B-1 SCREENING QUESTIONS: The following questions will help us determine your eligibility to be vaccinated today.

1. Are you feeling sick today? □Yes □No □ I don't know

2. Have you ever received a dose of the COVID-19 vaccine? □Yes □No □ I don't know
If yes, which product? _____. Date Received? _____

3. Check all that apply to you:

□ Am a female between ages 18 and 49 years old
□ Have a history of myocarditis or pericarditis
□ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies
□ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
□ Take immunosuppressive drugs or therapies
□ Take a blood thinner
□ Am currently pregnant or breastfeeding
□ History of Guillain-Barré Syndrome (GBS)
□ Am a male between ages 12 and 29 years old
□ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
□ Have a weakened immune system (i.e., HIV infection, cancer)
□ Have a bleeding disorder
□ Have a history of herparin-induced thrombocytopenia (HIT)
□ Have received dermal fillers

SECTION B-2 ALLERGIC REACTION QUESTIONS: This would include a severe reaction [e.g. anaphylaxis] that required treatment with epinephrine or EpiPen or that caused you to to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.

1. Have you ever had an allergic reaction to a component of COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures? □Yes □No □ I don't know

2. Have you ever had an allergic reaction to Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids? □Yes □No □ I don't know

3. Have you ever had an allergic reaction to a previous dose of COVID-19 vaccine? □Yes □No □ I don't know

4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? □Yes □No □ I don't know

SECTION C INSURANCE - PATIENT OR AUTHORIZED PERSON TO COMPLETE

	Medical Card
Insur. Plan/Plan ID:	
Member/Recip't ID#:	
Group Number:	

Medicare	Medicare Part B
Medicare Number*:	
Last 4 Digits of SSN**:	

* Number on the red, white and blue Medicare card
**For insurance confirmation purposes only.

Is the patient the cardholder? □Yes □No □ I don't know
If no, please provide the cardholder's name, date of birth and relationship:
_____

_____

If uninsured, I attest that I do not have any medical or pharmacy insurance. □ Yes

DATA BELOW TO BE COMPLETED BY HEALTHCARE PROVIDER

Complete BEFORE administration:

1. I have reviewed the **Patient Information** and **Screening Questions.** Initial _____

2. I have verified that this is the **vaccine requested** by the patient. Initial _____

3. This vaccine is appropriate for this patient based on the **Age Guidelines and Other Guidelines** provided by federal and/or state regulations and company policies. Initial _____

   3a. Does this patient have a high-risk medical condition? Initial _____
   If yes, please list medical condition(s): _____

4. The vaccine NDC matches the NDC on the bottom of this form and the NDC on the patient leaflet. (Perform a **3-way NDC match**) Initial _____

5. I have verified the Expiration Date is greater than today's date and have entered the Lot # and expiration date in section F below. Initial _____

SECTION E Complete DURING the patient interaction:

1. I confirm(ed) the patient's **Name, DOB and requested vaccine,** and verified it matches the information on the VAR form. Initial _____

2. I have reviewed the **Screening Questions** and answers. Initial _____

3. The patient received a **EUA Fact Sheet.** Initial _____

SECTION F Complete AFTER the vaccine administration:

Vaccine / NDC / Manufacturer (Check one)	Dosage	Site of Administration	EUA Fact Sheet Published Date
□ Pediatric Pfizer / 52967-1055-4 / Pfizer □ Pfizer / 59267-1000-01 / Pfizer □ Moderna / 80777-273-99 / Moderna	□ Dose 1 □ Dose 2 □ Dose 3 □ Booster	□ Left (L) Deltoid □ Right (R) Deltoid	

Clinician's name (print): _____ Clinician's signature: _____

Administration Date: _____ Observation Time: ☐ 15 mins ☐ 30 mins

Lot #:_____ Lot Expiration Date:_____

Rev: 01/11/2022