McALLEN ISD

1st Dose___2nd Dose __
5-11 years old (orange cap) X

PATIENT'S INFORMATION (PLEASE CLEARLY PRINT)

Last Name:	First Name:	Middle Name:

Address:	City:	State:	Zip Code:	County

Date of Birth: ____/____/_____(Month/Day/Year)	Sex: M / F	Age:	Phone	Email:

Mother's First Name:		Mother's Maiden Name:	
Race:			
Ethnicity:			

COVID-19 VACCINATION INFORMATION

The Pfizer 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.

Mcallen ISD is authorized to administer the Pfizer COVID-19 Vaccine based on guidance developed by the Centers for Disease Control and Prevention. To optimize vaccine response, you will receive 2 doses separated by 21 days.
Side effects reported in clinical trial of this vaccine include, but may not be limited to, injection site pain, redness, or swelling, fatigue, headache, muscle pain, chills, fever, joint pain, nausea, or lymph node swelling. Such symptoms normally resolve within 24 hours and are typically mild but if severe should be reported to your health care provider and VAERS (link on the documentation provided).
If severe allergic symptoms develop (trouble breathing, chest pain, fast heartbeat dizziness, weakness, facial, tongue, or throat swelling, or rash) after your observation period is complete, please call 911 or proceed to the nearest Hospital Emergency Department.

SCREENING CHECKLIST FOR TODAY'S IMMUNIZATION

#	Question	Yes	No
1	Are you sick today?		
2	Have you had fever in the last 48 hours?		
3	Have you been diagnosed with COVID-19 infection within the last 90 days?		
4	Have you ever had a reaction to any COVID-19 vaccine components (mRNA, several different lipid ingredients)?		

If you answered "Yes" to questions 1-4, we would advise you to postpone vaccination for COVID-19 as follows:

- If sick, wait until your symptoms have resolved. If you are COVID+, wait until 90 days have elapsed since positive COVID-19 test.
- You should not take the Pfizer COVID-19 vaccine if your first COVID-19 vaccine was produced by another manufacturer.
- If you have a history of anaphylaxis to any ingredient of the Pfizer vaccine, you CANNOT receive this vaccine based on current guidance.

#	Question	Yes	No
5	Have you ever had a severe allergic reaction (anaphylactic) to a vaccine (including trouble breathing, hives, facial or tongue swelling, low blood pressure, fast heart rate) or other severe reaction to a vaccination?		
6	Do you have a history of severe allergic reaction to anything besides a vaccine, including other medications, insect stings, or bites?		
7	Do you take blood thinner, or do you have a bleeding disorder?		

If your answer to any of questions 5, 6, or 7 is "Yes", please notify the staff so that we can make the accommodations necessary to observe you more carefully following your vaccination, and if you have a bleeding tendency or are on blood thinners, we will watch you carefully for possible injection site bleeding.

#	Question	Yes	No
8	Do you a weakened immune system?		
9	Do you have a history of seizures?		

CONSENT FOR VACCINATION

I have been provided with and have read the EUA Fact Sheet for the COVID-19 vaccine, the COVID-19 Vaccine Consent Form, and any additiona information provided. I have had the opportunity for my questions to be answered by a medical professional, and I understand that a series of two vaccines will be required. I understand the known risks and benefits of vaccination and understand that not all risks may have yet been established.
I know that I am consenting to this vaccine series under an EUA in response to the COVID-19 Pandemic. I request to proceed with vaccination.
I agree to remain on site for 15 minutes after vaccination and that my condition may warrant post vaccination observation for at least 30 minutes.

Date:	**Time:**	**Relationship to Patient:**

Print Name	**Signature**
Administered by McAllen ISD	**Date**

Vaccine	Vaccine Info	Site	Manufacturer	Lot #	Expiration Date
COVID-19 Vaccine	**Series** ☐1st ☐2nd	Deltoid: ☐Left ☐Right	☒Pfizer	FK5127	1/13/2022
Date of Administration	**Vaccine Administrator Signature/Title or Credentials**			**Location** McAllen ISD	

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

Texas Immunization Registry (ImmTrac 2) Disaster Information Retention Consent Form

(Please print clearly)
*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: ☐ Female ☐ Male Telephone ___-___-____ Email address ____

Client's Address ____ Apartment # / Building # ____

City ____ State ____ Zip Code ____ County ____

Mother's First Name ____ Mother's Maiden Name ____

Race (select all that apply)	Ethnicity (select only one)
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American	☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race	☐ Not Hispanic or Latino
☐ Recipient Refused	☐ 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, ImmTrac2 will retain disaster-related information received from health-care providers for a period of 5 years. At the end of the 5 year retention period, client-specific disaster-related information will be removed from the Registry unless consent is granted to retain the client information in ImmTrac2 beyond the 5 year retention period.

The Texas Department of State Health Services (DSHS) encourages your voluntary participation in the Texas Immunization Registry.

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 5 year retention period. I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac2"). Once in ImmTrac2, 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 ImmTrac2 Registry beyond the 5 year retention period and my consent to release information from the Registry, at any time by written communication to the Texas Department of State Health Services, ImmTrac2 Group – MC 1946, P.O. Box 149347, Austin, Texas 78714-9347.

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

____ 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.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

Upon completion, please fax or mail form to the DSHS ImmTrac2 Group or a registered Health-care provider.

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

Texas Department of State Health Services • ImmTrac2 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.**