

**PATIENT'S INFORMATION (PLEASE CLEARLY PRINT)**

Last Name:		First Name:		Middle Name:	
Address:			City:	State:	Zip Code:
Date of Birth: ___/___/___ (Month/Day/Year)		Sex: M / F	Age:	Phone:	Email:
Mother's First Name:		Mother's Maiden Name:			
Race: American Indian or Alaska Native		Native Hawaiian or Other Pacific		Asian	White
Ethnicity: Hispanic or Latino		Not Hispanic or Latino		Black or African American	
				Other	

**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**

1	Are you sick today?	Yes	No
2	Have you had fever in the last 48 hours?	Yes	No
3	Have you been diagnosed with COVID-19 infection within the last 90 days?	Yes	No
4	Have you ever had a reaction to any COVID-19 vaccine components (mRNA, several different lipid ingredients)?	Yes	No
<b>If you answered "Yes" to questions 1-4, we would advise you to postpone vaccination for COVID-19 as follows:</b>			
<ul style="list-style-type: none"> <li>• If sick, wait until your symptoms have resolved. If you are COVID+, wait until 90 days have elapsed since positive COVID-19 test.</li> <li>• You should not take the <b>Pfizer</b> COVID-19 vaccine if your first COVID-19 vaccine was produced by another manufacturer.</li> <li>• If you have a history of anaphylaxis to any ingredient of the <b>Pfizer</b> vaccine, you CANNOT receive this vaccine based on current guidance.</li> </ul>			
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?	Yes	No
6	Do you have a history of severe allergic reaction to anything besides a vaccine, including other medications, insect stings, or bites?	Yes	No
7	Do you take blood thinner, or do you have a bleeding disorder?	Yes	No
<b>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.</b>			
8	Do you have a weakened immune system?	Yes	No
9	Do you have a history of seizures?	Yes	No

**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 additional 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		Date

Vaccine	Vaccine Info	Site	Manufacturer	Lot #	Expiration Date
COVID-19 Vaccine	Series <input type="checkbox"/> 1st <input type="checkbox"/> 2nd	Deltoid: <input type="checkbox"/> Left <input type="checkbox"/> Right	<input checked="" type="checkbox"/> Pfizer	FK5127	1/13/2022
Date of Administration	Vaccine Administrator Signature/Title or Credentials			Location <b>McAllen ISD</b>	



(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)	
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African-American	<input type="checkbox"/> Hispanic or Latino	
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Other Race	<input type="checkbox"/> Not Hispanic or Latino	
<input type="checkbox"/> Recipient Refused			<input type="checkbox"/> 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](http://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.**