COVID-19 Vaccine Registration/Consent Form 2021

Patient Information (Please print clearly)

Buff ID #:_____ **Email:** _____

Last name: _____ **First Name:**_____ **Middle Initial:**_____

Date of Birth:_____/_____/_____ **Mobile Phone #:**_____

Address:_____ **Apt/Room#**_____

City:_____ **State:**_____ **Zip:**_____ **County:**_____

Faculty:____ **Staff:**_____ **Student:**_____ **Other:**_____

CONSENT

By signing below, you acknowledge that you have received or were offered a copy of the HIPAA Privacy notice and "Fact Sheet for Recipients and Caregivers" for the COVID-19 vaccine.

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by WTAMU COVID-19 Vaccine Clinic, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

Screening

Y/N	Is Patient 18 years of age or older?
Y/N	Is Patient sick today (within 48 hours)?
Y/N	Is Patient currently under quarantine due to a known COVID-19 exposure?
Y/N	Has Patient had a serious reaction to a vaccine in the past?
Y/N	Has Patient received a monoclonal antibody infusion in the past 90 days?
Y/N	Has the patient had any vaccines/shots in the last 14 days?
Y/N	Does the patient have allergies to medications, vaccine or latex?
Y/N	Is the Patient pregnant of is there a chance she could become pregnant during the next month?

Information Statement: Please check off the following statements:

- I have been given a copy and have read the COVID-19 Vaccine Information Sheet.
- I have been given a chance to ask questions which were answered to my satisfaction.
- I understand the benefits and risks associated with this vaccine; I am requesting that the vaccine be given to me.
- I know the risks of the disease the vaccine prevents.
- I know the benefits and risks of each vaccine.
- I am an adult who can legally consent for myself.
- I acknowledge that I have been instructed to remain at the vaccination location for a minimum of 15 minutes for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.
- I understand this vaccine requires a single dose to be effective.
- I give consent to release my information to the Texas Department of State and Health Services (DSHS) and the Texas Immunization Registry (ImmTrac2).

(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.)

Signature of Person to Receive Vaccine:

X_____ Date Signed:_____

FOR NURSE TO COMPLETE

Date Vaccine Administered: _____ Time: _____

Vaccine Manufacturer: Johnson and Johnson:_____

Vaccine Lot Number:_____ Expiration Date of Vaccine:_____

Site of Injection: (IM)

Left Deltoid: _____ Right Deltoid: _____

Patient to complete Observation:

15 Minutes: _____ 30 Minutes: _____

Signature and Title of Vaccine Adminstrator:

Signature:_____
Title:_____ Date:_____