Ashley PEDIATRICS Day and Night Clinic

Industrial Health Works OCCUPATIONAL & FAMILY MEDICINE CLINIC

Moderna COVID-19 Vaccine Consent Form

First Name: _____ Last Name: _____

Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Race: ☐White ☐ Black ☐ Asian ☐ Pacific Islander ☐ American Indian/Alaskan Native ☐ None Specified ☐ Refused	Hispanic Ethnicity: ☐ Yes ☐ No ☐ Unknown ☐ Refused

HEALTH HISTORY	YES	NO	UNKNOWN
1. Are you feeling sick? Or, were you exposed to a confirmed COVID-19 patient, in quarantine for COVID exposure, or tested positive for COVID in the past 14 days?	☐	☐	☐
2. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19? Date_____	☐	☐	☐
3. Have you ever had a severe allergic reaction (ex. anaphylaxis to food)? (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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.) Allergy _____	☐	☐	☐
4. Have you ever had a serious reaction after any vaccination or injectable medication, including vaccine components such as lipid nanoparticles, polysorbates, or polyethylene glycol (PEG)?	☐	☐	☐
5. Have you ever received a dose of COVID-19 vaccine? ☐ Another product_____ Date _____ Manufacturer: ☐ Moderna ☐ Johnson & Johnson ☐ Pfizer	☐	☐	☐
6. In the past 14 days, have you received any other vaccines?	☐	☐	☐
7. Have you received passive antibody therapy as a treatment for COVID-19 in the past 90 days?	☐	☐	☐
8. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐	☐	☐
9. Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐	☐
10. Are you breastfeeding or pregnant?	☐	☐	☐

CONSENT AND RELEASE STATEMENT

I wish to receive a vaccination against COVID-19. I, the undersigned, certify that I am (a) the patient and at least 18 years of age, (b) the legal guardian of the patient and confirm that the patient is at least 18 years of age, or (c) authorized to consent for the vaccination for the patient named above. I voluntarily give consent for Ashley Pediatrics or Industrial Health Works to administer the COVID-19 vaccine and understand this product has not been approved or licensed by the FDA but has been authorized for emergency use by the FDA under an emergency use authorization. I understand the risks and benefits of this vaccine. I have had an opportunity to ask questions which have been answered to my satisfaction. I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital. I hereby release and hold harmless Ashley Pediatrics or Industrial Health Works for 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 listed above. I understand there is no out of pocket cost to the patient for the vaccine or its administration but my insurance or the uninsured program will be billed to cover the cost of the services provided.

SIGNATURE _____ DATE _____

For Office Use Only:

Manufacturer: Moderna	**Lot #**	**Route:** Intramuscular
Dose number ☐ 1 or ☐ 2	***Exp. Date:** ___ /___ /___	***Date Administered:** ____ /____ /___
Administered by:	**Vaccine Administration Clinic:**	**Injection Site (Deltoid)** ☐ L ☐ R
		Vaccine Dose: 0.5 ml

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

ImmTrac2 Immunization Registry
DISASTER INFORMATION RETENTION CONSENT FORM

(Please print clearly)

Client's Last Name

Client's First Name

Client's Middle Name

Client's Date of Birth (__/__/____)

*A parent, legal guardian or managing conservator must sign this form if the client is younger than 18 years of age.

Client's Gender: ☐ Male ☐ Female

Client's Address

Apartment #

Client's Telephone (___-___-____)

City

State

Zip Code

County

Mother's First Name

Mother's Maiden Name

ImmTrac2, the Texas immunization registry, 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.texas.gov 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 • ImmTrac2 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.**

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COVID-19 PATIENT QUESTIONNAIRE

1. Have you developed any of these symptoms recently? Mark all that apply.

Notify staff immediately!

- ☐ Shortness of breath or difficulty breathing
- ☐ Chest Pain
- ☐ Fever
- ☐ Chills
- ☐ Cough
- ☐ Fatigue
- ☐ Muscle weakness or body aches
- ☐ Headache
- ☐ New loss of taste or smell
- ☐ Sore throat
- ☐ Congestion or runny nose
- ☐ Nausea or vomiting
- ☐ Diarrhea

☐ New ☐ Established

Insurance & Member ID

_____

Reason for Visit

_____

Car Color & Make

_____

Medication Allergies

_____

Primary Care Doctor

_____

☐YES ☐NO 2. Have you been exposed to a COVID-19 suspected or infected person?

☐YES ☐NO 3. Are you fully vaccinated against COVID-19?

☐YES ☐NO 4. Have you traveled in the last month?

☐YES ☐NO 5. Have you had any family or friends visit or have you visited any family or friends recently?

☐YES ☐NO 6. If you visited family or friends, did everyone "social distance" and wear a face mask?

Patient Name _____ Date of Birth _____

Home Address _____

Phone _____ Alternate Phone _____

Emergency Contact & Phone _____

Preferred Pharmacy & Phone _____

I, the undersigned, certify that I have given true, accurate, and complete information on this questionnaire to the best of my knowledge.

Questions asked by (initial): _____

Patient/Guardian Signature _____ Date _____