TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER

COVID-19 Vaccine Consent Form 2020 - 2021- Dose 2

FOR NURSE TO COMPLETE			
Date Vaccine Administered:	Vaccine Manufacturer:	Pfizer	Moderna
Vaccine Lot Number:	Expiration Date of Vaccine:		
Site of Injection: Left Deltoid / Right Deltoid			
Signature and Title of Vaccine Administrator:			

R#: ______________________ **TTUHSC E-mail:**______________________**@ttuhsc.edu**

Name: ______________________________________ **Date of Birth:** ______________

Last First M.I.

School: ☐ Medicine ☐ Graduate Biomed Science
☐ Nursing ☐ Health Professions
☐ Pharmacy

Clinical Department/School:______________________________

Title: ☐ Faculty ☐ Staff ☐ Resident/Fellow ☐ Student

Direct Patient Contact: Yes / No

Allergies: ____

Yes / No Severe anaphylactic hypersensitivity to eggs

Yes / No History of Guillain-Barre Syndrome

Yes / No Moderate to severe illness at this time

Yes / No History of severe reaction or allergy to vaccine component

Yes / No **Pregnant at this time**

Information Statement: Please check off the following statements.

☐ I have been given a copy and have read the 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'm requesting that the vaccine be given to me.

☐ I give consent to release my information to DSHS and the Immtrac system

Signature of Person to receive vaccine:

X ______________________________________ **Date Signed:** ______________

MANDATORY: Do you receive care from any Texas Tech Physician? ☐ **NO** ☐ **YES**