TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER

COVID-19 Vaccine Consent Form 2020 - 2021

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