



SARS-CoV-2 Vaccine Consent Form 2020 - 2021

FOR NURSE TO COMPLETE

Date Vaccine Administered:

Vaccine Manufacturer:

Vaccine Lot Number:

Expiration Date of Vaccine:

Site of Injection: Left Deltoid

Right Deltoid

Signature and Title of Vaccine Administrator:

Unit: _____ E-mail: _____

Name: _____ Date of Birth: _____
Last First M.I.

Employer: TTUHSC TDCJ Title/Position: _____
Hospital Other: _____

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 am requesting that the vaccine be given to me.
- I give consent to release my information to the Texas Department of Criminal Justice (TDCJ), DSHS, and the Immrac system

Signature of Person to receive vaccine:

X _____ Date Signed: _____