TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER™
Managed Care

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

Hospital Other: _____

Title/Position: _____

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 DSHS and the Immtrac system

Signature of Person to receive vaccine:

X _____ **Date Signed:** _____

v. 1/5/21