North Austin Pediatrics, P.A.

COVID-19 Vaccine Consent Form

Date: _____

Patient's Name (the person getting the vaccine): _____

Patient's Date of Birth: _____

Do you have insurance? ____Y ____N

Has the patient ever received a dose of COVID-19 vaccine? If so, what was the date of the first dose _____	____Y ____N
Are you sick today? Is the patient in quarantine or isolation currently for COVID-19?	____Y ____N
Has the patient ever had an allergic reaction (anaphylaxis) to anything?	____Y ____N
Has patient had a severe allergic reaction to a component of the COVID-19 vaccine, including polysorbate or polyethelene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures?	____Y ____N
Has the patient ever had a positive COVID-19 test?	____Y ____N
Has the patient received passive antibody therapy (monoclonal antibodies or convalescent Serum) as treatment for COVID-19?	____Y ____N
Does patient have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	____Y ____N
Does patient have a bleeding disorder or are you taking a blood thinner?	____Y ____N
Is the patient in quarantine or isolation for COVID-19?	____Y ____N
Is the patient pregnant or breastfeeding?	____Y ____N

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I (the patient) agree to WAIT near the clinic location for 15 minutes after receiving the vaccine, or 30 minutes if there is a previous history of a severe allergic reaction to a vaccine or injectable medication.

I (the patient) understand the vaccine is being given under an emergency use authorization from the FDA and has only been approved for emergency use. It is possible, though unlikely, that final approval of the vaccine will not ultimately be given.

I (the patient) understand this vaccine requires two doses and that due to vaccine supply shortages that North Austin Pediatrics, P.A. will not be able to guarantee that I (the patient) will be able to receive a second dose. North Austin Pediatrics, P.A. will work to acquire adequate doses but cannot guarantee that North Austin Pediatrics, P.A. will receive their requested amounts from manufacturer because of supply chain restrictions outside of their control.

I (the patient) understand there are no guarantees this vaccine will provide immunity to me, and that I (the patient) should continue protective measures including masking, social distancing, and handwashing. North Austin Pediatrics, P.A. makes no warranties, express or implied, including but not limited to, implied warranties of merchantability or fitness for a particular purpose regarding the vaccine or its effectiveness.

I (the patient) certify I (the patient) do not have any contraindications to receiving this vaccine as outlined in the vaccine information sheet-- including but not limited to a history of significant allergic reactions.

I (the patient) understand that the common risks associated with the COVID-19 vaccine include, but are not limited to, pain, redness or swelling at the site of injection, tiredness, headache, muscle pain, chills, join pain, fever, nausea, feeling unwell or swollen lymph nodes (lymphadenopathy). I (the patient) understand that the vaccine may cause a severe allergic reaction which can include anaphylaxis (difficulty breathing), swelling of the face and throat, a fast heartbeat, a rash all over the body, dizziness and/or weakness. I (the patient) understand that these may not be all the side effects of the COVID-19 vaccine as the vaccine is still being studies in clinical trials. I (the patient) also understand that it is not possible to predict all possible side effects or complications which could be associated with the vaccine. I (the patient) understand that the long-term side effects or complications of this vaccine are not known at this time.

I (the patient) will contact my physician or go to an urgent care or emergency room for assistance if I (the patient) have any concerns or adverse reactions.

I (the patient) understand that there are no data on the safety of COVID 19 in pregnant or lactating women and I (the patient) have consulted with my personal physician for information on the risks and benefits of the vaccine. I (the patient) further understand that North Austin Pediatrics, P.A. and its providers or staff will not be liable to the patient or the patient's fetus/child for any harm related to acceptance of the vaccine.

I (the patient) understand North Austin Pediatrics, P.A. and its providers or staff are immune under both Federal and State law from liability related to this vaccine. This means I (the patient) will not be compensated by North Austin Pediatrics, P.A. and its providers or staff for any adverse effects experienced.

I (the patient) understand that the vaccination is being given by North Austin Pediatrics, P.A. The owner and/or operator of this site, their affiliates, officers, directors, employees and agents expressly disclaim any responsibility for the vaccination. My consent is given in light of this knowledge, and in consideration of North Austin Pediatrics, P.A giving the COVID-19 vaccine. I (the patient), for myself and my heirs and family members, administrators, trustees, executors, assigns and successors in interest do hereby agree to release and hold harmless North Austin Pediatrics, P.A, its subsidiaries, divisions, affiliates, successors, assigns, officers, trustees, employees, volunteers and agents from an against any and all demands, damages, losses, costs, expenses, obligations, liabilities, claims, actions and cause of action (whether any of which is groundless or otherwise) of any nature whatsoever (including, without limitation, reasonable attorney's fees and court costs) by reason of or resulting, in any way, from any and all acts, accidents, events, occurrences, omissions and the like related to, or arising out of, directly or indirectly, my receipt of this COVID-19 vaccine.

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I (the patient) understand that North Austin Pediatrics, P.A will be required to provide certain demographic data, as well as any reaction or side effects experienced to state and Federal authorities and consent to this disclosure. I (the patient) further understand and agree that North Austin Pediatrics, P.A is required to submit COVID-19 vaccine administration data to the Texas Immunization Information System (IMMTRAC), and report moderate and severe adverse events following vaccination to the Vaccine Adverse Event Reporting System (VAERS).

I (the patient) was provided an opportunity to ask questions, which were answered to my satisfaction. I (the patient) understand the benefits and risks of the vaccine and request the vaccine be given to me. I (the patient or parent/guardian if patient is under 18 years of age) have read, understand and agree to all of the above and I (the patient or parent/guardian if patient is under 18 years of age), hereby give my consent to the staff of North Austin Pediatrics, P.A to give the patient a COVID-19 vaccine.

THERE IS NO COST TO YOU. I (the patient) hereby authorize North Austin Pediatrics, P.A to apply for benefits on my behalf for all services rendered with my insurance. I (the patient) certify the information provided regarding my insurance coverage is correct. I (the patient) further authorize the release of any and all information necessary for my insurance company to determine benefits for services rendered. I (the patient) request payment of authorized benefits be made payable to North Austin Pediatrics, P.A on my behalf.

If I (the patient) do not have insurance, I (the patient) have truthfully indicated above and will not be responsible for the cost. I (the patient) acknowledge that if I (the patient) do not have insurance, my information will be submitted to the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA) so that North Austin Pediatrics, P.A will be funded for the cost of my immunization administration.

I (the patient or parent/guardian if patient is under 18 years of age) have read the above and have provided North Austin Pediatrics, P.A with true and correct information and will notify North Austin Pediatrics, P.A of any changes in health insurance coverage.

Patient Name: _____

Signature of Patient (or parent/guardian if patient < 18 yrs): _____

Name of Signer: _____

If patient under 18 years of age, relationship to the patient: _____

Date: _____

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

Texas Immunization Registry (ImmTrac 2)
Disaster Information Retention Consent Form

(Please print clearly)

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

First Name _____ Middle Name _____ Last Name _____

Date of Birth (mm/dd/yyyy) _____/_____/_____ Gender: ☐ Female ☐ Male Telephone _____ - _____ - _____ Email address _____

Client's Address _____ Apartment # / Building # _____

City _____ State _____ Zip Code _____ County _____

Mother's First Name _____ Mother's Maiden Name _____

Race (select all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race
☐ Recipient Refused

Ethnicity (select only one)

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Recipient Refused

The Texas Immunization Registry (ImmTrac2) 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.state.tx.us 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 • ImmTrac 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.**