BORGER Health Mart PHARMACY

# VACCINE ADMINISTRATION RECORD

NAME_____ DATE OF BIRTH_____

STREET ADDRESS_____ CITY_____

STATE_____ ZIP CODE_____ PHONE NUMBER_____

PRIMARY CARE PHYSICIAN_____ OFFICE PHONE_____

NAME OF VACCINE YOU ARE REQUESTING _____

| | |
|---|---|
| **Are you sick today?** | NO____YES____UNSURE____ |
| **Are you allergic to any, MEDICATIONS, eggs, or vaccine components?** | NO____YES____UNSURE____ |
| **Have you ever had a serious reaction after a vaccine?** | NO____YES____UNSURE____ |
| **Is it possible that you are pregnant or may become pregnant in the next 3 months?** | NO____YES____UNSURE____ |
| **Have you had any vaccines in the last 4 weeks?** | NO____YES____UNSURE____ |
| **Do you or anyone living with you have cancer, leukemia, or AIDS?** | NO____YES____UNSURE____ |
| **Do you or anyone living with you take prednisone, cortisone, steroids, or anticancer drugs?** | NO____YES____UNSURE____ |
| **During the past year have you received a blood transfusion, plasma, or immunoglobulin?** | NO____YES____UNSURE____ |

Have you had a pneumonia shot? _____ Have you had a shingles shot? _____

X_____ DATE _____

SIGNATURE AUTHORIZING VACCINE AND RELEASE

I have received the current "What you need to know" statement sheet, and have read of have had explained to me the information on this sheet about this vaccine. I have had a chance to ask questions that were answered to my satisfaction. I certify that I am at least 18 years old (or if I am not 18 years old am at least 12 years old) and hereby give my consent (or if I am less than 18 years old, my legal guardian gives consent) to the staff at Borger Pharmacy to administer the influenza vaccine. I understand that it is not possible to predict all possible side effects of complications associated with vaccines. I understand the benefits and risks of the vaccine and request that it be given to me or to the person named below for whom I am authorized to make this request. I hereby and for my heirs, executors, administrators, successors, and assigns release, acquit and forever discharge Borger Pharmacy and its subsidiaries and affiliates and each of their agents, employees, officers, directors, servants, successors, heirs, executors, administrators of and from any and all claims, actions, causes of action, demands, rights, damages, costs, loss of service, expenses and compensation whatsoever, which the undersigned now has/have/or which may hereafter accrue on account of or in any way growing out of any and all known and unknown, foreseen personal injuries and property damage and the consequences thereof resulting or to result from the immunization.

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| | | | | | |
|---|---|---|---|---|---|
| DATE VACCINE GIVEN | | TIME VACCINE GIVEN | | DATE PROTOCOL SIGNED | 4/1/2020 |
| AUTHORIZING PRESCRIBER | | PRESCRIBER ADDRESS | | CLINIC LOCATION IF NOT AT PHARMACY | |

| | |
|---|---|
| Vaccine Trade Name | |
| NDC | |
| Manufacturer | |
| Lot and Expiration Date | |

| | |
|---|---|
| Vaccine Trade Name | |
| NDC | |
| Manufacturer | |
| Lot and Expiration Date | |

| | | | | | |
|---|---|---|---|---|---|
| SITE OF INJECTION | L R IM DELTOID SQ ARM | DOSE | 0.5ML | NEEDLE SIZE | 5/8" 1" |

| | | | |
|---|---|---|---|
| ADMINISTERING PHARMACIST | | INITIAL | |

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

# ImmTrac2 Immunization Registry
# DISASTER INFORMATION RETENTION CONSENT FORM

(Please print clearly)

**Client's Last Name**

**Client's First Name**

**Client's Middle Name**

**Client's Date of Birth** (__/__/____)

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

**Client's Gender:** ☐ Male ☐ Female

**Client's Address**

**Apartment #**

**Client's Telephone** (___-___-____)

**City**

**State**

**Zip Code**

**County**

**Mother's First Name (if client is younger than 18 years of age)**

**Mother's Maiden Name (if client is younger than 18 years of age)**

ImmTrac2, the Texas immunization registry, 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.texas.gov 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 • ImmTrac2 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.**

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

# ImmTrac2 Immunization Registry
## FORMULARIO DE CONSENTIMIENTO DE RETENCIÓN DE INFORMACIÓN SOBRE EL DESASTRE

(Favor de escribir claramente con letra de molde)

**Apellido del Cliente**

**Nombre del Cliente**

**Segundo Nombre del Cliente**

**Fecha de Nacimiento del Cliente**

*Uno de los padres, el tutor legal o el custodio administrador debe firmar este formulario si el cliente es menor de 18 años de edad.

**Género:** ☐ **Masculino** ☐ **Femenino**

**Dirección del Cliente**

**Apartamento #**

**Teléfono del cliente**

**Ciudad**

**Estado**

**Código Postal**

**Condado**

**Nombre de la Madre (si el cliente es menor de 18 años de edad)**

**Apellido de Soltera de la Madre (si el cliente es menor de 18 años de edad)**

Nombre de la Madre (si el cliente es menor de 18 años de edad) Apellido de Soltera de la Madre (si el cliente es menor de 18 años de edad) ImmTrac2, el registro de inmunización de Texas, ha sido designado como el sistema de información y seguimiento para inmunizaciones, antivirales y otros medicamentos administrados a individuos durante la preparación o respuesta a un desastre o emergencia de salud pública. A partir del momento en que se declare finalizado el evento, ImmTrac2 retendrá la información relacionada con el desastre recibida por profesionales de la salud durante un periodo de 5 años. Al final del periodo de retención de 5 años, la información del cliente relacionada con el desastre se removerá del registro a menos que se dé el consentimiento para retener la información en ImmTrac2 más allá del periodo de retención de 5 años.

*El Departamento Estatal de Servicios de Salud de Texas (DSHS) le anima a participar voluntariamente en el registro de inmunización de Texas.*

**Consentimiento de retención de información relacionada con el desastre y dar a conocer la información a entidades autorizadas**

Entiendo que, al dar mi consentimiento a continuación, autorizo al DSHS a que retenga mi información relacionada con el desastre (o la de mi hijo[a]) más allá del periodo de retención de 5 años. Además entiendo que el DSHS incluirá esta información en el registro central de inmunización del estado ("ImmTrac2"). Una vez que mi información relacionada con el desastre (o la de mi hijo[a]) esté en ImmTrac2, puede ésta por ley ser accedida por:

- las agencias estatales, con el propósito de ayudar con los esfuerzos de prevención y control de enfermedades transmisibles y su coordinación y
- los médicos o demás profesionales de la salud legalmente autorizados para administrar vacunas, antivirales y otros medicamentos, para el tratamiento del cliente como paciente.

Entiendo que puedo retirar el consentimiento para retener información en el registro ImmTrac2 más allá del periodo de retención de 5 años y mi consentimiento para dar a conocer la información del registro, en cualquier momento mediante comunicación escrita dirigida a Texas Department of State Health Services, ImmTrac2 Group – MC 1946, P. O. Box 149347, Austin, Texas 78714-9347.

**Con mi firma a continuación, DOY mi consentimiento para que se retenga mi información relacionada con el desastre (o la de mi hijo[a] si es menor de 18 años de edad) en el registro de inmunizaciones de Texas más allá del periodo de retención de 5 años.**

Cliente (o padre / madre, tutor legal o custodio administrador): _____

Nombre en letra de molde

Fecha: _____ Firma: _____

**Notificación Sobre Privacidad:** Tan solo por unas cuantas excepciones, usted tiene el derecho de solicitar y de ser informado sobre la información que el Estado de Texas reúne sobre usted. A usted se le debe conceder el derecho de recibir y revisar la información al requerirla. Usted también tiene el derecho de pedir que la agencia estatal corrija cualquier información que se ha determinado sea incorrecta. Diríjase a *http://www.dshs.texas.gov* para más información sobre la Notificación sobre privacidad. (Referencia: Government Code, sección 552.021, 552.023, 559.003 y 559.004)

**Al rellenarlo, mándelo por fax o correo postal al Grupo ImmTrac2 del DSHS o a un proveedor de salud inscrito.**

**¿Tiene preguntas?** (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com • ImmTrac2 DC

**Texas Department of State Health Services • ImmTrac2 Group – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347**

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