

Pfizer COVID-19 Vaccine Form: 2021

HN2 Site for Data Entry: _____	Client Birthdate: _____
Date of Service: _____	Client ID #: _____
Highest Trained Provider: _____	Additional Providers: _____
Responsible Person Info: (for clients under age 18)	Last Name: _____ First Name: _____
	Race: _____ Sex: _____ Birthdate: _____
	Relationship: _____ Phone: _____
Financial Eligibility: COVID-19 vaccine series number: Imm. Up to Date for Age after Visit: Interval to Next Imm: VIS Names:	A = Native American / Alaskan Native N = No Insurance Circle one: 1 st dose 2 nd dose 3 rd dose or booster dose Y = Yes N = No Circle one: 21 days (3 weeks) or 0 days Pfizer COVID-19 Fact Sheet for Recipients

Data Entry to Complete	Initials
HN2 Client Register; Insurance; Signature	
HN2 Encounter	

Section 1: Information about Patient to Receive COVID-19 Vaccine *(please print)*

PATIENT NAME (Last) If applicable, Suffix	(First)	(M.I.)	PATIENT'S MAIDEN NAME	COUNTY OF RESIDENCE	
PATIENT BIRTHDATE (mm/dd/yyyy)	PATIENT AGE	GENDER Male Female	Mother's Maiden Last Name for GRITS		
ETHNICITY <i>(Please Circle)</i> Not Hispanic/Latino Hispanic Latino	RACE <i>(Please Circle)</i> Asian Black White Multi-racial Native American/Alaska Native Native Hawaiian/Other Pacific Islander		MARITAL STATUS <i>(Please circle)</i> Single Married Divorced Separated Widowed		
MAILING ADDRESS			PHONE NUMBER (home, mobile, work)		
CITY	STATE	ZIP CODE	E-MAIL (personal, work)		
EMERGENCY CONTACT PERSON		RELATIONSHIP	PHONE NUMBER FOR EMERGENCY CONTACT		

Section 2: **Medical Information:** *The following questions will help us to determine if this person can receive the COVID-19 vaccine.*

1. Are you feeling sick today?	Yes	No
2. Have you ever received a dose of COVID-19 vaccine? If yes, please circle the type: Moderna, Pfizer, J&J, or other _____	Yes	No
3. Have you ever had an allergic reaction to: a component of the COVID-19 vaccine (polyethylene glycol or polysorbate) or a previous dose of the COVID-19 vaccine?	Yes	No
4. Have you ever had an allergic reaction to another vaccine or an injectable medication?	Yes	No
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of the COVID-19 vaccine, or any vaccine or injectable medication? This would include pet, food, environmental, or oral medications	Yes	No
6. Are you a female between the ages of 18-49 years old or are you a male between the ages of 12-29 years of age?	Yes	No
7. Do you have a history of myocarditis or pericarditis?	Yes	No
8. Do you have a history of Guillain-Barre Syndrome?	Yes	No
9. Are you pregnant or breastfeeding?	Yes	No
10. Have you been diagnosed with multisystem inflammatory syndrome after a COVID-19 infection?	Yes	No
11. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	Yes	No
12. Do you have a bleeding disorder or are you taking a blood thinner? Do you have a history of heparin-induced thrombocytopenia?	Yes	No
13. Do you have a weakened immune system (i.e., cancer, organ transplant, HIV), or do you take immunosuppressive drugs or therapies?	Yes	No
14. Are you a resident of a long-term care facility (e.g., nursing home, senior living, or assisted living)?	Yes	No
15. Are you 18-64 years of age with underlying medical conditions? Please list:	Yes	No
16. Are you at high risk of COVID-19 exposure because of occupational or institutional setting?	Yes	No

Section 3: **CONSENT:** *If this consent form is not filled in completely, signed and dated, the patient will not be vaccinated.*

I GIVE CONSENT to DPH District 10 for the patient named above to receive the COVID-19 vaccine. I acknowledge that the patient and medical information provided above is correct. I have been given a copy of and have read (or have had explained to me) the information in the Pfizer COVID-19 Fact Sheet for Recipients and Caregivers. I have been given an opportunity to ask questions and they were answered to my satisfaction. I believe I understand the benefits and risks of the COVID-19 vaccine and request it be given to me or to the patient named above for whom I am authorized to make this request. I understand that it is recommended to wait at least 15 minutes at the clinical site after receiving the immunization in case of a reaction to the vaccine.

Patient/Guardian Signature: _____ **Relationship:** _____ **Date:** _____

HN2 Code	Vaccine Description	Source	Age Range Dosage/Route	Manufacturer Trade Name	NDC	Lot #	Site	
							LD	RD
mRNA; LNP-S	Pfizer-BioNTech COVID-19 Vaccine	StSupl	> = 12 years 0.3 mL	Pfizer-BioNTech COVID-19 Vaccine	59267-1000-02			Intramuscular