Northeast Health District: Pfizer COVID-19 Vaccine Consent Form

HN2 Site for Data Entry: _____ Client Birthdate: _____
Date of Service: _____ Client ID #: _____
Highest Trained Provider: _____ Additional Providers: _____
Responsible Person Info: *Last Name:* _____ *First Name:* _____
(for clients under age 18) *Race:* _____ *Sex:* _____ *Birthdate:* _____
Relationship: _____ *Phone:* _____
Financial Eligibility: A = Native American / Alaskan Native N = No Insurance
COVID-19 vaccine series number: Circle one: 1st dose 2nd dose 3rd dose **or** booster dose
Imm. Up to Date for Age after Visit: Y = Yes N = No
Interval to Next Imm: 21 days, 28 days, 2 months, or 6 months
VIS Names: 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 *(Please Circle)* Not Hispanic/Latino Hispanic Latino	RACE *(Please Circle)* Asian Black White Multi-racial Native American/Alaska Native Native Hawaiian/Other Pacific Islander		MARITAL STATUS (Please circle) 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	Manufacturer Trade Name	NDC	Lot #	Site / Route
PFIZER-BNT-S	Pfizer (mRNA; LNP-S; 30 mcg/0.3mL)	StSupl	> = 12 years 0.3 mL	Pfizer-BioNTech COVID-19 Vaccine	59267-1000-02 59267-1000-03		LD RD Intramuscular
PFIZER-BNT-PED-S	Pfizer - **PEDIATRIC** (mRNA; LNP-S; 10 mcg/0.2mL)	StSupl	5 – 11 years 0.2 mL	Pfizer-BioNTech COVID-19 Vaccine	59267-1055-04 59267-1055-02		LD RD Intramuscular

Revised 11/4/2021 WRH Nurse Signature _____ Date:_____