# 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 M = Insured/Vaccines Covered
COVID-19 vaccine series number: Circle one: 1st dose, 2nd dose, Additional, or Booster Dose
Imm. Up to Date for Age after Visit: Y = Yes N = No
Interval to Next Imm: _____ (days/weeks/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.*

| Please answer the health questions below: | Yes | No | Do Not Know |
|---|---|---|---|
| 1. Are you feeling sick today? | | | |
| 2. Have you ever received a dose of COVID-19 vaccine? *If yes, which vaccine product: ☐ Pfizer ☐ Moderna ☐ Janssen ☐ Novavax ☐ Other: _____ | | | |
| 3. Have you ever had a severe allergic reaction that required treatment with Epinephrine or EpiPen, or caused you to go to the hospital, caused hives, swelling, or respiratory distress including wheezing? | | | |
| *Was the severe reaction after receiving a COVID-19 vaccine? | | | |
| *Was the severe reaction after receiving another vaccine or another injectable medication? | | | |

4. Check all that apply to you:
- ☐ Have a history of myocarditis or pericarditis
- ☐ Have a history of Guillain-Barre Syndrome
- ☐ Have a bleeding disorder or take blood thinners
- ☐ Have a history of heparin-induced thrombocytopenia (HIT)
- ☐ Am currently pregnant or breastfeeding
- ☐ Have received dermal fillers
- ☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
- ☐ Diagnosed with multisystem inflammatory syndrome (MIS-C or MIS-A) after a COVID-19 infection

5. Check all that apply to you:
- ☐ Have a weakened immune system (i.e., HIV infection, cancer): If yes list condition: _____
- ☐ Take immunosuppressive drugs or therapies: If yes, please list: _____

## 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 (Circle one) | NDC | Lot # | Site / Route | |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | Intramuscular | |
| COVID-19-PFIZER-BNT-**TS-S** | Pfizer-BioNTech COVID-19 Vaccine - TRIS-SUCROSE (mRNA; LNP-S, pres-free; 30 mcg/0.3mL; MDV) | StSupl | > = 12 years | 0.3 mL 1st, 2nd, Additional | 59267-1025-04 | | LD | RD |
| | | | | | | | Intramuscular | |
| COVID-19-PFIZER-BNT-**PED-S** | Pfizer-BioNTech COVID-19 Vaccine - PEDIATRIC (mRNA; LNP-S, pres-free; 10 mcg/0.2mL; MDV) | StSupl | 5y – 11y | 0.2 mL 1st, 2nd, Additional | 59267-1055-04 | | LD | RD |
| | | | | | | | Intramuscular | |
| COVID-19-PFIZER-BNT-**PED-6MO-S** | Pfizer-BioNTech COVID-19 Vaccine - PEDIATRIC, TRIS-SUCROSE, Age 6MO-4Y (mRNA; LNP-S, pres-free; 3 mcg/0.2mL) | StSupl | 6m – 4y | 0.2 mL 1st, 2nd, 3rd | 59267-0078-04 | | LD | RD |
| | | | | | | | Intramuscular | |



Nurse Signature _____ Date: _____