**PLEASE PRINT**

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| **Patient *FIRST* Name**:  | ***LAST* Name**: | **MI**: |
| **Maiden Name** (Optional): |  |
| **DOB**: / / | **Current Age**: **Sex**: [ ]  F [ ]  M [ ]  Other  |
| **Race:**[ ] White [ ] Black or African American [ ] Asian[ ] American Indian or Alaskan Native [ ] Other[ ] Native Hawaiian or Other Pacific Islander [ ] Unknown |
| **Ethnicity:** [ ] Hispanic or Latino [ ] Non-Hispanic or Latino [ ] Unknown |
| **Do you have a disability?** [ ] Yes [ ] No [ ] Prefer not to answer |  |
| **Address**: | **City**:  |  **State**: | **Zip**: |
|  |  |  |
| **Cell Phone**: ( ) | **Alternate Phone:** ( ) |  |
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| **The following questions will help determine if there is any reason you should not receive a COVID immunization injection. Questions should be answered for the person who will be vaccinated.***If a question is not clear, please ask a healthcare provider to explain.* |
| 1. | Check individual’s age group:Age 6 months – 4 years?...........................................................................................................Age 5-11 years?.........................................................................................................................Age 12 years and up?................................................................................................................  | [ ]  [ ]  [ ]   |  |
| 2. | History of any immediate allergic reaction, of any severity, after a previous dose of mRNA COVID-19 vaccine or any of its components (including polyethylene glycol [PEG]) or polysorbate?.............................................................................................................................. | [ ]  Yes | [ ]  No |
|  | **Cause/Allergy:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| 3. | History of immediate allergic reaction of any severity to any substance?................................  | [ ]  Yes | [ ]  No |
|  | **Cause/Allergy:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| 4.  | History of myocarditis or pericarditis following receipt of any COVID-19 vaccine?.................. | [ ]  Yes | [ ]  No |
| 5. | Ever received a COVID-19 vaccine?........................................................................................... **Primary Series 1ST Dose Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­\_ **Manufacturer:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **2nd Dose Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Manufacturer**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Immunocompromised Individuals** **3rd Dose Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_­\_ **Manufacturer**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Booster dose Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Manufacturer**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  Yes | [ ]  No |
| 6.  | Sick today, including symptomatic/asymptomatic infection with COVID-19?.......................... | [ ]  Yes | [ ]  No |
| 7. | Moderate or severe immunocompromise?.............................................................................. | [ ]  Yes | [ ]  No |
| 8.  | Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?............................... | [ ]  Yes | [ ]  No |
| 9. | Pregnant or breastfeeding?....................................................................................................... | [ ]  Yes | [ ]  No |

**Request for Administration of COVID-19 Vaccine for the above-named recipient:** I acknowledge that I have received the Vaccine Information Statement or Emergency Use Authorization Information Sheet and the Tennessee Department of Health’s Notice of Privacy Practices. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I am aware that, to provide protection against the virus that causes COVID-19, additional doses may be required. I acknowledge that I may receive a reminder for additional doses by text (if cell phone number provided, standard messaging rates may apply), phone call, or mail.

**PATIENT/PARENT OR GUARDIAN/POWER OF ATTORNEY SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE: \_\_\_\_\_\_\_\_\_\_\_**

 ***This consent is valid for 12 months from date signed.***

***FOR OFFICIAL USE ONLY***

**[Enter County] County Health Department**

**Vaccination Site Location [address]\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| Nursing Immunization **[INJECTION #1]** Documentation |
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| **Manufacturer:** Pfizer  |   |  |   |   |
| **Dose:** [ ]  **Ages 12 and up :** 0.3 mL (30 mcg) [ ]  **Ages 5 - 11 :** 0.2 mL (10 mcg) | [ ]  **Ages 6 mos - 4 yr**: 0.2 mL (3 mcg) |
| **Site Administered:** [ ] Right Deltoid | [ ] Left Deltoid | [ ] [Other]  | **Route: IM** IM |  |
| **Lot Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Expiration Date: / /** | [ ]  **EUA Date 12 and up:** 05/17/2022 |
| **Date Given: /**   **/**  | **Provider number:** \_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  **EUA Date 5-11:** 06/17/2022 |  |
| **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  **EUA Date 6 mos-4 yrs:** 06/17/2022 |  |
| *Signature indicates immunization given according to PHN Protocol* |  |  |
| [ ] Vaccine NOT given secondary to contraindication:[ ] Verbal Order obtained from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to proceed with immunization per protocol; readback completed. Special Instructions: **PHN Signature:** |

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| Nursing Immunization **[INJECTION #2]** Documentation |
| [ ] All initial screening questions have been reviewed and discussed. |
| **Manufacturer:** Pfizer |   |  |   |   |
| **Dose:** [ ]  **Ages 12 and up :** 0.3 mL (30 mcg) [ ]  **Ages 5 - 11 :** 0.2 mL (10 mcg) | [ ]  **Ages 6 mos - 4 yr**: 0.2 mL (3 mcg) |
| **Site Administered:** [ ] Right Deltoid  | [ ] Left Deltoid | [ ] [Other]  |  |  **Route**: **IM** |
| **Lot Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Expiration Date: / /** | [ ]  **EUA Date 12 and up:** 05/17/2022 |
| **Date Given: /**   **/**  | **Provider number:** \_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  **EUA Date 5-11:** 06/17/2022 |  |
| **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  **EUA Date 6 mos-4 yrs:** 06/17/2022 |  |
| *Signature indicates immunization given according to PHN Protocol* |  |  |
| [ ] Vaccine NOT given secondary to contraindication:[ ] Verbal Order obtained from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to proceed with immunization per protocol; readback completed. Special Instructions: **PHN Signature:** |

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| Nursing Immunization Documentation |
| [ ] All initial screening questions have been reviewed and discussed. |
| **Manufacturer:** Pfizer |   |  |   |   |
| **Dose:** [ ]  **Ages 12 and up :** 0.3 mL (30 mcg) [ ]  **Ages 5 - 11 :** 0.2 mL (10 mcg) | [ ]  **Ages 6 mos - 4 yr**: 0.2 mL (3 mcg) |
| **Site Administered:** [ ] Right Deltoid  | [ ] Left Deltoid | [ ] [Other]  |  |  **Route**: **IM** |
| **Lot Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Expiration Date: / /** | [ ]  **EUA Date 12 and up:** 05/17/2022 |
| **Date Given: /**   **/**  | **Provider number:** \_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  **EUA Date 5-11:** 06/17/2022 |  |
| **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  **EUA Date 6 mos-4 yrs:** 06/17/2022 |  |
| *Signature indicates immunization given according to PHN Protocol* |  |  |
| [ ] Vaccine NOT given secondary to contraindication:[ ] Verbal Order obtained from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to proceed with immunization per protocol; readback completed. Special Instructions: **PHN Signature:** |