COVID-19 Pfizer-BioNTech Vaccination

PLEASE PRINT

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:** ( )

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?..... ☐ Yes ☐ No
   Primary Series 1ST Dose Date: _____ **Manufacturer:** _____
   2nd Dose Date: _____ **Manufacturer**: _____
   Immunocompromised Individuals
   3rd Dose Date: _____ **Manufacturer**: _____
   Booster dose Date_____ **Manufacturer**: _____
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.

COVID-19 Pfizer-BioNTech Vaccination

FOR OFFICIAL USE ONLY

[Enter County] County Health Department
Vaccination Site Location [address]_____

Nursing Immunization **[INJECTION #1]** Documentation
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:**

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:**

Nursing Immunization Documentation
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