COVID-19 Pfizer-BioNTech Vaccination

PLEASE PRINT

Patient Last Name:	**First Name**:	**MI**:
Sex: ☐ M ☐ F	**DOB**: / /	**Current Age**:
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. *If a question is not clear, please ask a healthcare provider to explain.*		
1. Has the person to be vaccinated ever received a COVID-19 vaccine?..... Date _____ Manufacturer_____	☐ Yes	☐ No
2. Does the person to be vaccinated have an allergy to a component of the vaccine?..... Allergies:_____	☐ Yes	☐ No
3. Has the person to be vaccinated ever had a severe (anaphylaxis) reaction to an injectable or intravenous medication or vaccine?...[**Defer to RMD**].....	☐ Yes	☐ No
4. Has the person to be vaccinated ever had a severe (anaphylaxis) reaction due to any cause?...[**observe for 30 minutes**].....	☐ Yes	☐ No
5. Is the person to be vaccinated sick today, including symptomatic or asymptomatic infection with COVID-19?.....	☐ Yes	☐ No
6. Has the person to be vaccinated received any vaccine in the past 14 days?.....	☐ Yes	☐ No
7. Has the person to be vaccinated received passive antibody therapy for COVID-19 in the past 90 days?.....	☐ Yes	☐ No
8. Is the person to be vaccinated younger than 16 years old?.....	☐ Yes	☐ No
9. Is the person to be vaccinated 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, two doses of this same vaccine may be required. I acknowledge that I may receive a reminder for a second dose by text (if cell phone number provided, standard messaging rates may apply), phone call, or mail.

I hereby release Tennessee Department of Health, their affiliates, employees, directors, and officers from any and all liability arising from any accident, act of omission or commission, which arises during vaccination.

PATIENT/PARENT OR GUARDIAN/POWER OF ATTORNEY SIGNATURE: _____ DATE: _____

This consent is valid for 12 months from date signed.

COVID-19 Pfizer-BioNTech Vaccination

[Enter County] County Health Department

Vaccination Site Location [address]_____

AREA FOR OFFICIAL USE ONLY
Nursing Immunization **[INJECTION #1]** Documentation

Manufacturer: Pfizer

Dose: 0.3 mL **Route**: IM

Site Administered: ☐ Right Deltoid ☐ Left Deltoid ☐ [Other]

Lot Number: _____ **Expiration Date:** / / **EUA Date:** Revised 12/2020

Date Given: / / **Provider number:** _____

Signature: _____
Signature indicates immunization given according to PHN Protocol

☐ Vaccine NOT given secondary to contraindication:

AREA FOR OFFICIAL USE ONLY
Nursing Immunization **[INJECTION #2]** Documentation

☐ All initial screening questions have been reviewed and discussed.

Manufacturer: Pfizer

Dose: 0.3 mL **Route**: IM

Site Administered: ☐ Right Deltoid ☐ Left Deltoid ☐ [Other]

Lot Number: _____ **Expiration Date:** / / **EUA Date:** Revised 12/2020

Date Given: / / **Provider number:** _____

Signature: _____
Signature indicates immunization given according to PHN Protocol

☐ Vaccine NOT given secondary to contraindication: