Pfizer

COVID-19 VACCINE ADMINISTRATION FORM

Patient Encounter Form

PATIENT DEMOGRAPHICS

Name: _____

Last First Middle

Address: _____

Birthdate: _____ Age: _____ County _____ Cellphone _____

Gender: ☐ Male ☐ Female Hispanic/Latino ☐ **Y** ☐ **N**

Race (check all that apply): ☐ White ☐ Black ☐ American Indian/Alaskan ☐ Hawaiian/Pacific Islander ☐ Asian ☐ Multiracial

INFORMED CONSENT FOR VACCINES

I understand that the COVID-19 vaccine I am receiving is being administered to me pursuant to a U.S. FDA Emergency Use Authorization (EUA). I (or my legal surrogate decision maker) have received and read the EUA Fact Sheet via access on the SCCH Website and/or a paper copy for recipients of this vaccine, which fully explains to me the risks and benefits of receiving this vaccine. I agree that Sullivan County Community Hospital has not made any guarantees to me about the result(s) of this vaccination, and I understand that I may experience side effect(s) after receiving this vaccine. If I experience a severe reaction after vaccination, I will call 9-1-1 or go to the nearest hospital. By signing below, I agree that it is my personal decision to receive this EUA COVID-19 vaccine, and I give Sullivan County Community Hospital permission to administer this vaccine to me.

X _____ _____ _____

Signature of Patient/Parent/Legal Guardian/Representative **Relationship** **Date**

FOR CLINIC STAFF USE ONLY: Please complete all information below

Have you been COVID positive in the last 90 days? ☐ **Y** ☐ **N**
If yes, instruct on possibility of increased immune response

Have you had Convalescent Plasma or Antibody Infusion in the last 90 days? ☐ **Y** ☐ **N** (If yes, don't vaccinate)

Has the patient ever had an allergic reaction to the vaccine or any of its components (i.e., polyethylene glycol)?
☐ **Y** ☐ **N** (If yes, don't vaccinate)

Do you have a history of anaphylaxis due to <u>any</u> cause other than vaccine reaction?
☐ **Y** ☐ **N** (If yes, must observe for 30 mins)

Is the patient pregnant? ☐ **Y** ☐ **N** (If yes, can vaccinate)

Is the patient moderately or severely acutely sick today?
☐ **Y** ☐ **N** (If yes, must observe for 30 mins)

Have you ever had an allergic reaction to an injectable therapy (i.e., IV or shot)? ☐ **Y** ☐ **N** (If yes, must observe for 30 mins)

Injection site: ☐ **R or** ☐ **L Deltoid** Time: _____ Patient Vaccination Refused: _____

Signature and Title of Provider: _____

Description	CPT	Administration	ICD-10 Code	Manufacturer	Lot Number	Expiration
Pfizer – SARS-CoV2 COVID-19 0.3mL	91303	0031A-SINGLE Dose	Z23	Pfizer BioNTech		

Post Vaccination Observation Observation End Time: _____

☐ 15 min

☐ No Side Effects Reported/Observed

☐ Side Effects Reported/Observed
(see Record of Reported/Observed Side Effects)

☐ 30 min

☐ No Side Effects Reported/Observed

☐ Side Effects Reported/Observed
(see Record of Reported/Observed Side Effects)