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 Approval (Initial Series) or Emergency Use Authorization (EUA) (Booster or 3rd Dose). 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

Self-Attestation for 3rd Dose and Booster Dose:

Patient's 1st, 2nd, or 3rd dose? _____ If 3rd dose (must be at least 28 days past 2nd dose), what was the date of 2nd dose? _____

Are you moderately or severely immunocompromised? □ **Y** □ **N** If Yes (_____), and it is ≥ 28 days, then may give 3rd dose
Pt Initials

Booster Dose? □ **Y** □ **N** Date of 2nd Pfizer shot: _____ (must be ≥ 6 months) (Must have had Pfizer)

Are you: (Choose one)
65 or older _____ Pt Initials
18 or older with an underlying medical condition _____ Pt Initials
LTC Resident _____ Pt Initials
18 or older and work in a high risk of exposure setting _____ Pt Initials

By initialing, you are attesting to the above information.

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

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

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

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

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	91300	0001A – First Dose 0002A – Second Dose 0003A – Third Dose 0004A – Booster	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)

COVID-19 VACCINE ADMINISTRATION
Record of Reported/Observed
Side Effects

Patient Name: _____ DOB: _____

Vaccination Date/Time: _____

Vaccine: Pfizer Johnson & Johnson

Side Effects: _____

_____

Action Taken: ☐ Physician Notified ☐ Patient to ER ☐ 911

☐ Patient refused intervention

Anaphylaxis Protocol Initiated: ☐ Y ☐ N

Other: _____

_____

_____

_____

_____

Signature: _____ Date: _____

☐ VAERS Completed Signature: _____ Date: _____