**PLEASE PRINT**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Patient *FIRST* Name**: | ***LAST* Name**: | | | **MI**: |
| **Maiden Name** (Optional): | | |  | |
| **DOB**: / / | **Current Age**: **Sex**:  F  M  Other | | | |
| **Race:**White Black or African American AsianAmerican Indian or Alaskan Native Other  Native Hawaiian or Other Pacific Islander Unknown | | | | |
| **Ethnicity:** Hispanic or Latino Non-Hispanic or Latino Unknown | | | | |
| **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. | Younger than 12 years old?....................................................................................................... | Yes | No |
| 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. | Ever received a COVID-19 vaccine?...........................................................................................  **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­\_\_\_\_\_\_ **Manufacturer:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes | No |
| 5. | Sick today, including symptomatic/asymptomatic infection with COVID-19?.......................... | Yes | No |
| 6. | Received passive antibody therapy for COVID-19 in the last 90 days?..................................... | Yes | No |
| 7. | Received any vaccine in the past 14 days?................................................................................ | Yes | No |
| 8. | 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.

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

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

**Anderson County Health Department**

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

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| **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:** 05**/**2021 | |
| **Date Given: /**   **/** | **Provider number:** \_\_\_\_\_\_\_\_\_\_\_\_\_ | | (Optional) |  |
| **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  |  |
| *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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| **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:** 05**/**2021 | |
| **Date Given: /**   **/** | **Provider number:** \_\_\_\_\_\_\_\_\_\_\_\_\_ | | (Optional) |  |
| **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  |  |
| *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:** | | | | |