**PLEASE PRINT**

|  |  |  |
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| **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 |
| **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:** |