PFIZER-BIONTECH COVID-19 Vaccine Administration Record

Please Print Information about person to receive vaccine

Last name	First	Middle initial	Birth date	Age
Street address		**City**	**Zip code**	
Telephone #				
Male ☐ **Female** ☐ **Email Address:**				

I have read or have had explained to me the information in the Emergency Use Authorization (EUA) about the COVID-19 vaccine. I believe I understand the benefits and risks of the COVID-19 vaccine and ask that the COVID-19 vaccine be given to me or the person named above for who I am authorized to make this request. I authorize billing of the administration of vaccination to Medicare, Medicaid, or insurance. I hereby acknowledge that I received a copy of the "Notice of Privacy Practices" from the Macon County Health Department dated 9/23/2013. _____ (initials)

CDC recommends waiting 15 minutes after receiving immunizations.

Signature of person to receive the COVID-19 vaccine, or the person authorized to make request:

X_____ Date: _____

Office use only

Dose # 1 ☐	**Dose # 2** ☐
Manufactured by: Pfizer EUA given: _____ Site of vaccine: right left deltoid Date Administered: / / Lot #:	Manufactured by: Pfizer EUA given: _____ Site of Vaccine: right left deltoid Date Administered: / / Lot #:

Clinic/office address: Macon County Health Department, 1221 E Condit St, Decatur, IL 62521

Signature & Title of Vaccine Administrator_____

Medicare #_____

Medicaid #_____

Insurance:
Member ID/Group # _____

Screening Checklist for Contraindications to the PFIZER-BIONTECH COVID-19 Vaccination

For patients to be vaccinated: The following questions will help us determine if there is any reason we should not give you the Pfizer-Biontech vaccination today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't know
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Has the person to be vaccinated ever had a severe allergic reaction to any vaccine or injectable (intramuscular, intravenous, or subcutaneous) in the past?	☐	☐	☐
3. Has to person to be vaccinated previously been infected with COVID-19 and received monoclonal antibodies or convalescent plasma as part of treatment in the last 90 days? (must be minimum 90 days since treatment)	☐	☐	☐
4. Is the person to be vaccinated today pregnant or breastfeeding?	☐	☐	☐
5. Has the person to be vaccinated today previously received a COVID-19 vaccine?	☐	☐	☐

Form Completed by _____ Date _____

Form Reviewed by _____ Date _____

(www.immunize.org) Technical content reviewed by CDC