

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 <input type="checkbox"/> Female <input type="checkbox"/> 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

| | |
|--|--|
| <p>Dose # 1 <input type="checkbox"/></p> <p>Manufactured by: Pfizer</p> <p>EUA given: _____</p> <p>Site of vaccine: right left deltoid</p> <p>Date Administered: / /</p> <p>Lot #:</p> | <p>Dose # 2 <input type="checkbox"/></p> <p>Manufactured by: Pfizer</p> <p>EUA given: _____</p> <p>Site of Vaccine: right left deltoid</p> <p>Date Administered: / /</p> <p>Lot #:</p> |
|--|--|

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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has the 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) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has the person to be vaccinated today previously received a COVID-19 vaccine? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Form Completed by _____ Date _____

Form Reviewed by _____ Date _____

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