Do not staple or fold

Wood County Health Department COVID-19 Vaccine Registration and Consent for PFIZER Vaccine

First Name:	Middle:	Last:
Date of Birth:	Age:	Sex: ☐ Female ☐ Male ☐ Other ☐ Unknown
If recipient is under 18, a parent or legal guardian **must** be present.		
Do you consider yourself Hispanic or Latino? ☐ Yes ☐ No ☐ Don't Know/Prefer not to say		
Which category or categories best describe your race?	☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ☐ Unknown/Prefer not to say	
Street address:		
City, State and Zip:		
Phone Number:	Email Address:	
If an emergency happens today, who should we contact?		
Name:	Phone number:	
List names and dates of all previous COVID vaccines:		
1st dose: ☐ Pfizer ☐ Moderna ☐ Johnson & Johnson	Date:	2nd dose: ☐ Pfizer ☐ Moderna ☐ N/A Date:

Please select the primary reason you are receiving the COVID-19 vaccine. (Please check only one box.)

Age: 5-11 ☐ 12-39 ☐ 40-49 ☐ 50-59 ☐ 60-64 ☐ 65-69 ☐ 70-74 ☐ 75-79 ☐ 80 or older ☐

Place of Residence or Occupation

Assisted Living Facility – Resident ☐ or Staff ☐
Childcare Services Worker ☐
Congregate Care Facility – Resident ☐ or Staff ☐
Emergency Medical Services (EMTs/Paramedics) ☐
Funeral Services Worker ☐
Healthcare Worker
  Hospital – Clinical ☐, Administrative ☐ or Ancillary Staff ☐
  Non-Hospital – Clinical ☐, Administrative ☐ or Ancillary Staff ☐
Law Enforcement, Corrections, Firefighter ☐
School (K-12) Staff ☐
Skilled Nursing Facility (RCF) – Resident ☐ or Staff ☐
State of Ohio
  Dept. of Dev. Disabilities (DODD) – Resident ☐ or Staff ☐
  Dept. of Rehabilitation & Correction LTC – Resident ☐ or Staff ☐
  Mental Health and Addiction Services (MHAS) – Resident ☐ or Staff ☐
  Veterans Home – Resident ☐ or Staff ☐

Health Condition

ALS (amyotrophic lateral sclerosis) ☐
Bone marrow transplant recipients ☐
Cancer ☐
Chronic kidney disease ☐
Chronic obstructive pulmonary disease (COPD) ☐
Congenital or early onset conditions with intellectual or developmental disabilities ☐
Congenital or early in life conditions that carried into adulthood without intellectual or developmental disabilities ☐
Diabetes type1 ☐ or type 2 ☐
End stage renal disease ☐
Heart disease ☐
Obesity ☐
Pregnant ☐

Screening Questions

Question			
Are you sick today? (fever, congestion, cough)	☐ Yes	☐ No	☐ Not sure
Have you ever had a severe allergic reaction that required epi (epinephrine)?	☐ Yes	☐ No	☐ Not sure
Have you ever had any allergic reaction to a vaccine?	☐ Yes	☐ No	☐ Not sure
Have you been treated for COVID-19 in the last 90 days with passive antibody therapy (monoclonal antibodies or convalescent serum)?	☐ Yes	☐ No	☐ Not sure
Do you have a weakened immune system caused by something such as HIV or cancer?	☐ Yes	☐ No	☐ Not sure
Do you take medications or other therapies that suppress your immune system?	☐ Yes	☐ No	☐ Not sure
Do you have a bleeding disorder or are you taking a blood thinner?	☐ Yes	☐ No	☐ Not sure

Females: Are you pregnant? ☐ Yes ☐ No Are you breastfeeding? ☐ Yes ☐ No

Turn Over. >>>

Name: ______________________________ Date of Birth: ________________________

Informed Consent to Vaccinate - Initial each line.

If the person who is being vaccinated is age 17 or under, by signing below you agree that you are authorized to consent to the vaccination of the patient.

____ I am seeking the **Pfizer** vaccine today for:

- ____ A first or second dose of the original vaccine series (I agree to timely receive both the first and the second dose.)
- ____ A third dose for individuals who are determined to have certain kinds of immunocompromise
- ____ A booster dose

____ I understand that the common risks associated with the COVID-19 vaccine include but are not limited to pain, redness or swelling at the site of the injection, tiredness, headache, muscle pain, chills, joint pain, fever, nausea, swollen lymph nodes or generally feeling unwell.

____ I understand that the vaccine may cause a severe allergic reaction which may include anaphylaxis (difficulty breathing, swelling of the face and throat, a fast heartbeat, a rash all over the body, dizziness and/or weakness).

____ I understand that myocarditis (inflammation of the heart muscle) and pericarditis (inflammation of the lining outside the heart) have occurred in some people who have received the vaccine.

____ I understand that the above listed side effects may not be all the side effects of the COVID-19 vaccine.

____ I understand that the vaccine is still being studied in clinical trials.

____ I understand that all possible side effects or complications associated with the vaccine cannot be predicted.

____ I understand that any long-term side effects or future complications from this vaccine are unknown at this time.

____ I acknowledge that I have been given a copy, have viewed or had explained to me the Vaccine Information Fact Sheet about the vaccine to be administered to me and information about the disease.

____ I acknowledge I had the opportunity to ask questions and understand both the presently known benefits and the risks of this vaccine.

____ I acknowledge I had an opportunity to decline having this vaccine administered to me.

____ I acknowledge and understand that unless I request otherwise, a record of my vaccination shall be provided to a state-wide Immunization Registry for the purpose of immunization tracking, recall and recording.

____ I confirm that the person being vaccinated is old enough at the time of vaccination as approved or authorized.

____ I confirm that the person being vaccinated has not received a COVID vaccine from another manufacturer that would make receipt of a **Pfizer** COVID-19 vaccine today inconsistent with CDC guidance.

____ I certify that I am (a) at least 18 years of age, (b) the parent or legal guardian of the minor patient, or (c) acting at the request of the patient.

____ I hereby give my consent to the administration of a **Pfizer** COVID-19 vaccine.

Print name of person giving consent to vaccinate. (If under 18, print name AND date of birth of parent/legal guardian.) DOB: / /	Patient consent/signature (or parent/guardian)	Date of consent

Turn this form in before you leave the event.

Vaccination and Records Staff Use Only

Manufacturer: ☐ Pfizer	Anatomical Site: ☐ Left Deltoid ☐ Right Deltoid	
Lot Number:	Date of vaccine:	☐ 1st Dose ☐ 2nd Dose ☐ 3rd Dose
Expiration Date:	Vaccinator's Name:	