VERIFIED ID _____ NEXT APPT _____

Pfizer COVID-19 Vaccine Consent

Cedar County Public Health
400 Cedar St. Tipton, IA

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:	GENDER (circle one): Male Female Other

DATE OF BIRTH:	AGE:	PHONE NUMBER:
___ ___ / ___ ___ / ___ ___ ___ ___		

STREET ADDRESS:	CITY:	STATE:	ZIP CODE:

Name of Parent/Guardian (if 5-17 years of age):	Allergies (Please list):

PLEASE ANSWER ALL QUESTIONS	CIRCLE ONE	
1. Have you previously received a dose of COVID-19 vaccine? If yes, was it Pfizer, Moderna, or Johnson & Johnson?	YES	NO
2. Are you sick today? (For example: a cold, fever, or acute illness)	YES	NO
3. In the past 14 days have you been diagnosed with COVID-19 or been in close contact with someone with COVID-19?	YES	NO
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	YES	NO
5. Are you allergic to any foods, medications, vaccines, or latex? (For example: polysorbate, stool softeners, etc.?)	YES	NO
6. Have you ever had severe allergic reaction (anaphylaxis) requiring epinephrine, or for which you went to the hospital?	YES	NO
7. Do you have a bleeding disorder or are you taking a blood thinner?	YES	NO
8. Does your provider consider you immunocompromised, or do you take medication that effects your immune system?	YES	NO
10. Have you ever been diagnosed with MIS-C, myocarditis, or pericarditis?	YES	NO
11. **Dose Number 2 Only, Have there been any changes to your responses to the questions listed above? OR did you experience a severe reaction following a previous dose of COVID-19 vaccine? If yes, please describe:**	YES	NO

CONSENT FOR VACCINATION

- The Vaccine Information Sheet, or the Emergency use Authorization fact sheet have been made available to me and I understand the risks & benefits. I understand that this vaccine is approved by the FDA for people aged 16 years and up but is not approved for ages 15 years and under and is being offered under an FDA issued emergency use authorization.
- I give consent to Cedar County Public Health to vaccinate the person named above and to record the vaccination in the Iowa Immunization Registry Information System (IRIS).
- I certify that the information I provided for payment and consent is correct. I authorize release of all records required to act on this request. I authorize Medicare, Medicaid, Blue Cross Blue Shield, or other insurance to make payments directly to Cedar County Public Health.

Patient Signature: X _____ **Date:** _____

INSURANCE

INSURANCE COMPANY NAME: **UNINSURED** ◯

IDENTIFICATION NUMBER:

NAME OF CARD HOLDER:	BIRTH DATE OF CARD HOLDER: ___ ___ / ___ ___ / ___ ___ ___ ___

FOR OFFICE USE ONLY

◯ I have screened this patient for contraindications

◯ Left arm ◯ Right arm

Nurse's Signature: Date:

LOT #:

DOSE 1- IRIS	DOSE 1- NN	DOSE 1-BILLED

FOR OFFICE USE ONLY

◯ I have screened this patient for contraindications

◯ Left arm ◯ Right arm

Nurse's Signature: Date:

LOT #:

DOSE 2- IRIS	DOSE 2- NN	DOSE 2-BILLED