Covid-19 Vaccination & Administration Form

Patient Label Here

place label here for inpatients/those who have label generated; if outpatient/no label, please have patient provide information below

Name:		Date of Birth:
Address:		
Gender:	Race/Ethnicity:	Phone Number:
If you are insured, please list name of provider:	Plan Name: ________________ Group ID: ________________	Member ID: ________________

I have discussed any concerns regarding the COVID-19 Vaccine and any medical conditions I may have with my Healthcare Provider. I have either been advised by my Provider that I may proceed with the COVID-19 Vaccine <u>OR</u>, if my Provider has advised against receiving the COVID-19 Vaccine, I have taken the discussion into consideration and have decided to proceed with the COVID-19 Vaccine based on my own personal decision.

You must initial ALL statements if you are to receive the COVID-19 vaccination:	Initials
I have never had an allergic or anaphylactic reaction to a COVID-19 vaccine	
• I do not have known, active COVID-19 infection • In the past 90 days, I have not received monoclonal antibodies for COVID-19	

I understand that Emergency Use Authorization (EUA) is a pathway to make unapproved medical products available during public health emergencies.

Vaccine you are receiving today is Pfizer BioNTech **(Box to be checked by Beebe Staff Member)**		**Full FDA Approval Granted**	**Approved under FDA EUA (Emergency Use Authorization)**	**Risks**
Ages 16 and older Primary Series (2 doses)	☐	YES	N/A	See separate Pfizer Fact Sheet for Recipients and Caregivers for those who are ages 12 years and older or See separate Pfizer Fact Sheet for Recipients and Caregivers for those who are 5 through 11 years of age or See separate Pfizer Fact Sheet for Recipients and Caregivers for those who are 6 months through 4 years of age
Ages 12 through 15 years and additional dose(s) ages 12 and older *(except see age range below for Pfizer booster for different primary vaccination)*	☐	NO	YES	
Ages 5 through 11 years primary series and additional dose(s)	☐	NO	YES	
Ages 6 months through 4 years primary series (3 doses)	☐	NO	YES	
Booster(s) to those ages 18 and older who have completed primary vaccination with *another Covid-19 vaccine*	☐	NO	YES	

CON0901

Form #10679 1/19/21, 2/11/21, 5/8/21, 5/14/21, 7/14/21, 8/13/21, 9/24/21. 11/5/21, 12/16/21, 1/12/22, 4/6/22, 5/27/22, 7/4/22

Risks applicable to the vaccine:

- Injection site reactions: pain, tenderness, redness, swelling, where the shot is given can happen. Swelling of the lymph nodes. General Side Effects: fatigue, headache, muscle pain, joint pain, chills, nausea and vomiting, and fever.
- As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

I understand there are different brands of vaccine available and I am choosing to receive the brand offered today. I also know I have the option not to receive a Covid-19 vaccine.

I have read the separate *CDC V-Safe*℠ document provided to me and I agree to report side effects to my Provider and/or the *CDC via V-Safe*℠. In the event of a medical emergency, I understand that I should call 911 for immediate medical intervention.

I have read the separate *Pfizer Fact Sheet for Recipients and Caregivers* that has been provided to me.

My signature below verifies my initialed statements above, as well as agreement to release Beebe Healthcare and/or Beebe Medical Group and/or its employees from any and all claims arising out of the Covid-19 Vaccine I received.

If you are a resident of the State of Delaware, today's Covid-19 vaccination will be added to the Federal Immunization Registry and the Delaware State Immunization Registry so your Physician has access to that information.

Patient Signature   Date   Time   Signature of Healthcare Provider Providing Consent Information   Date   Time

Signature of Legal Representative of Patient (if patient unable to provide consent)

Printed Name of Legal Representative of Patient (if patient unable to provide consent)   Date   Time   Relationship to Patient

Witness to Signature (different from person who provided consent info.)   Date   Time

2nd Witness (needed if consent obtained via telephone/videoconference)   Date   Time

Certified Medical Interpretation:

I translated the wording in this form as well as any additional written information and interpreted verbal information provided to the patient or legal representative in the following language ____________________________________ and did so using the following method:

□ In Person Interpreter. Interpreter Signature: _________________________________
□ Over the Phone Interpreter ("OPI"). Print interpreter name: ___________________________ Identification Number: _______
□ Instant Remote Interpreting Service ("IRIS"). Print interpreter name: _____________________ Identification Number: _______

DO NOT WRITE BELOW THIS LINE

Manufacturer: **NDC:** **Vaccine Lot:** **Exp Date:**	**DELTOID R L**	**Route: Intramuscular**
	Clinician Signature: **Date:**	

Form #10679 1/19/21, 2/11/21, 5/8/21, 5/14/21, 7/14/21, 8/13/21, 9/24/21, 11/5/21, 12/16/21, 1/12/22, 4/6/22, 5/27/22, 7/4/22