COVID-19 VACCINE SCREENING AND AGREEMENT

Contact information – person being vaccinated.

Last name: ______________________________first name: _______________________Middle-IN ____

Age____________________

Date of Birth ___ /_____ /______

Primary phone number: ____________________________

Address (street or P.O. Box): ____

City: ____

State: ________________

ZIP code: _____________

Mother's name (last, first, middle - if younger than 18 years): ____

Mother's maiden name (if younger than 18 years): ___________________________________

Agreement

By signing below, I understand, recognize, approve, and agree that:

- I have received and read or had explained to me the Emergency Use Authorization Fact Sheet for the following COVID-19 vaccine: [Pfizer-BioNTech vaccine].
- I have had the chance to ask questions which were answered to my satisfaction, and I understand the benefits and risks of the COVID-19 vaccine as described.
- I agree to receive the COVID-19 vaccine for myself or for the person named above.

Signature of patient or parent/guardian: ____

Date: ______ / _____ / _______

_____Information collected on this form will be used to document that you have received vaccine(s). Information about your vaccine(s) may be shared through the Minnesota Immunization Information Connection (MIIC) with other health care providers, schools, health departments, and others authorized under law to receive it.

Health history

If you answer yes to any of these questions, the person giving you the vaccine may need more information from you before you get the vaccine:

Yes	No	Unknown	Question
Yes	No		Are you the correct age to receive the COVID-19 vaccine? • **Pfizer-BioNTech vaccine: You must be 12 years or older.**

Yes	No	Unknown	Question
Yes	No	Unknown	Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine?
Yes	No	Unknown	Immediate allergic reaction (within 4 hours) of any severity to a previous COVID-19 vaccine dose or known (diagnosed) allergy to a component of the vaccine or any of its ingredients (including polyethylene glycol [PEG] or polysorbate)?
Yes	No	Unknown	Immediate allergic reaction to any other vaccine or injectable therapy (e.g., shots in the muscle (intramuscular), in the vein (intravenous), or into the fatty tissue (subcutaneous)? Does not include allergy shots.
Yes	No	Unknown	Are you feeling sick today?
Yes	No	Unknown	Received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment in the past 90 days?
Yes	No	Unknown	Exposed to another person with known COVID-19 disease?
Yes	No	Not applicable	Have you ever received a dose of COVID-19 vaccine? If yes, list vaccine product and date received:
Yes	No	Not applicable	Did you have a delayed allergic reaction at the injection site (e.g., redness, itching) after a first dose of COVID-19 vaccine?
Yes	No	Unknown	Have you received any other vaccines (that were not COVID-19 vaccine) within the past 14 days?
Yes	No	Not applicable	Are you pregnant?

DO NOT WRITE BELOW THIS LINE

Vaccine information

COVID-19 Vaccine Presentation[1]	EUA Fact Sheet Date	Route[2]	Manufacturer[3]	Lot Number	Admin Site[4]	Person Admin[5]
COVID-19 (Pfizer)		IM	PFR		Left deltoid/Right deltoid	

1. **COVID-19 Vaccine Presentation** = lists specific product name (e.g., Pfizer, Moderna, Janssen, etc.)
2. **Route:** IM = Intramuscular
3. **Manufacturer:** PFR = Pfizer
4. **Site Vaccine Given:** LD = Left Deltoid, RD = Right Deltoid
5. **Signature or initials of person administering vaccine:** Can be used if more than one person is administering vaccines.

Signature and title of person administering vaccine: ____

Date administered: ___/___/_________