COMMUNITY HEALTH ALLIANCE

Vaccine Informed Consent (12+ PFIZER)

Patient Information

First Name: _____ Last Name: _____

Date of Birth: _____

Age: _____ ***MUST BE OVER 12**

Street: _____

City: _____ Zip Code: _____ Phone: _____ **Circle one**: Male Female

Insurance Information

Insurance Name: _____ BIN Number: _____

Medicare Beneficiaries:
SSN: _____

ID Number: _____ Group Number: _____ PCN Number: _____

☐ I do not have insurance at this time. *Citizenship/immigration documentation and health insurance are not required for a vaccine.*

COVID-19 Vaccine Information

Are you here to receive: ☐ **DOSE 1** ☐ **DOSE 2** ☐ **DOSE 3** ☐ **BIVALENT BOOSTER***

Date of most current BOOSTER: ___/___/___

*Bivalent booster may only be received 2 months after last booster dose.

Screening Questionnaire

	Yes	No
Are you sick today? If yes, list your symptoms: _____	☐	☐
Have you or anyone in your household been exposed to, diagnosed with, or has been placed in quarantine for COVID-19 in the past 14 days?	☐	☐
Have you received passive antibody therapy as treatment for COVID-19 in the past 90 days?	☐	☐
Have you received any vaccinations in the past 2 weeks? If yes, please list: _____	☐	☐
Have you ever had a severe allergic reaction (anaphylaxis) to any medications, latex, foods, pets or insects that required the use or treatment with epinephrine (EpiPen)? If yes, please list allergies: _____	☐	☐
Do you have an underlying medical condition like liver, kidney, heart disease, diabetes, or are immunocompromised?	☐	☐
Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐
For women: Are you currently pregnant?	☐	☐

I, the undersigned, hereby acknowledge that I have received the Emergency Use Authorization (EUA) vaccine sheet. I have had the opportunity to ask questions for the immunization to be administered to me or the person named above, for whom I am authorized to make this request. I agree to allow my immunization information to be stored and accessed by authorized users in Nevada's WebIZ. I voluntarily request that the vaccine be given to me or for the aforementioned person for whom I am authorized to make this request. By signing this document, I declare that the above information is true and accurate to the best of my knowledge. By signing this form, I am indicating that I understand that I can access a copy of Community Health Alliance's Notice of Privacy Practices related to health information by visiting https://www.chanevada.org/patients/privacy-policy.

☐ I authorize the vaccine to be administered by a trained student pharmacist.

Signature: _____ Date: _____

If under 18, print name of parent, guardian or caregiver: _____

Vaccine	Lot #	Exp Date	Route	Site	Dose	Date Given	Administered by:
Pfizer Monovalent			**IM**	**LD or RD**	**0.3 ml**		
Pfizer Bivalent			**IM**	**LD or RD**	**0.3 ml**		

□ Entered into WebIZ

Updated November 2022