Jefferson Healthcare

Place patient label here

COVID-19 Vaccine Patient Acknowledgment and Administration Record (Pfizer-BioNTech)

PATIENT INFORMATION

Last Name:	First Name:	Middle Name:	Birth Date:	Age:
Race/Ethnicity (*optional – for reporting purposes*):		Birth Gender (*optional - for reporting purposes*):		
Mailing Address:	City:	State:	Zip:	
Primary Telephone Number: ( )	Email Address:		Medicare Part A/B # (if applicable):	

FOR UNINSURED PATIENTS:

☐ By checking this box I attest that the following is true and accurate: I do not have any insurance, including but not limited to Medicare, Medicaid or any other private or government funded health benefit plan. I understand that to have my COVID-19 vaccine administration fee paid for by the U.S. Health Resources and Services Administration (HRSA) COVID-19 Program for Uninsured Patients I must provide one of the following: (a) my Social Security Number, (b) my state identification number (with state of issuance), or (c) my driver's license number (with state of issuance).

Number (SSN/ID/License – *circle one*): _____ State: _____

Vaccine Dose (check one): 1st □ 2nd □. If this is your second dose, when did you receive your first dose? (date): _____.
If this is your second dose, what vaccine was your first dose? Pfizer □ Moderna □ Don't Know □

EXCLUSION QUESTIONS

If patient answers 'yes' to either of these questions or patient's temperature is 100 F or greater, patient should not receive the COVID-19 vaccine at this time. Instruct the patient to contact their primary care provider for next steps.

Do you have a known history of a severe allergic reaction (e.g. anaphylaxis) to this vaccine or any components of the vaccine, such as lipids, potassium chloride, monobasic potassium phosphate, sodium chloride, dibasic sodium phosphate dihydrate, and sucrose? (Full list is available in the *Fact Sheet for Vaccine Recipients and Caregivers* or from your health care provider)	Yes	No
Are you under the age of 16 years?	Yes	No

VACCINE SCREENING QUESTIONS

If patient answers "yes" to any of these questions, provide patient counseling or instruct them to consult with their caregiver prior to receiving the vaccine.

In the past 14 days have you tested positive for COVID-19?	Yes	No
In the past 14 days have you had exposure to a person who tested positive for COVID-19 at a distance of six feet or less for a period of 15 or more minutes without wearing appropriate personal protective equipment (e.g. mask)?	Yes	No
Have you had a new onset of fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting or diarrhea?	Yes	No
In the past 90 days have you received passive antibody therapy as part of COVID-19 treatment?	Yes	No
In the past 14 days have you had any other vaccines?	Yes	No

Jefferson Healthcare

Place patient label here

Are you pregnant, breastfeeding or lactating, or do you plan to become pregnant?	Yes	No
Are you immune compromised or on any medicine that affects your immune system?	Yes	No
Do you have a bleeding disorder or are you on a blood thinner?	Yes	No
Do you have a history of severe allergic reaction (e.g. anaphylaxis) to another vaccine or injectable medication? If yes, what vaccine or injectable medication: _____	Yes	No

COVID-19 Immunization Acknowledgements

I have been given a copy of and have read (or have had explained to me) the information in the Emergency Use Authorization Fact Sheet for Vaccine Recipients and Caregivers or the Vaccine Information Statement for the vaccine I am receiving, and that it contains information about potential side effects and adverse reactions. I have had a chance to ask questions about the Fact Sheet/VIS, the vaccine itself and this form, which were all answered to my satisfaction.

I understand and accept that the vaccine I am receiving has been authorized by the U.S. Food and Drug Administration (FDA) for emergency use, pursuant to an Emergency Use Authorization and not the normal FDA approval process. I understand the benefits, alternatives and risks of receiving the vaccine to the extent they are known and unknown at this time. I understand that the vaccine I am receiving requires two doses of the same vaccine and that, as with all vaccines, there is no guarantee that I will become immune to COVID-19 or that I will not experience side effects. I have decided to receive the COVID-19 vaccine voluntarily and freely. I understand that I have the option to refuse the vaccine. I assume full responsibility for any result or reaction, and I hereby request that the vaccine be given to me or to the person named above for whom I am legally authorized to make this request.

I understand that I must remain in the vaccine administration area identified by my health care provider for at least 15 minutes, or as directed, after vaccination to be monitored for any adverse reaction. I understand that if I experience any suspected adverse reaction or side effects at any time, including but not limited to difficulty breathing, swelling of my face and/or throat, a fast heartbeat, rash all over my body or dizziness and weakness, I should contact my health care provider immediately.

X_____ _____

Signature of Patient/Authorized Representative **Date**

_____

Printed Name of Authorized Representative

Authorization to Request Payment: I authorize Jefferson Healthcare to release my health information and request payment. I certify that the information I have provided in applying for payment under Medicare, Medicaid or other insurance or government funded health benefit program is true and correct. I request that payment of authorized benefits be made on my behalf, and I hereby authorize release of all records necessary to act on this request.

Disclosure of Records: I understand and agree that Jefferson Healthcare may be required to or may voluntarily disclose my health information to my primary care physician, my insurance plan, other health systems or hospitals, and state and federal agencies or registries, for purposes of treatment, payment or health care operations or for other purposes authorized or required by law. I understand that Jefferson Healthcare will use and disclose my health information according to its Notice of Privacy Practices, which I have received or I may obtain at any time upon my request on Jefferson Healthcare's website.

Authorization to Disclose to Jefferson Healthcare Employee Health *(for JH Employees Only)*: I authorize this vaccine acknowledgment and administration record to be disclosed to and used by Jefferson Healthcare Employee Health for occupational health/employment purposes, and I authorize Jefferson Healthcare to maintain my vaccine records in both my electronic health record (i.e. Epic) and my employee health record to the extent required or permitted by law.

X_____ _____

Signature of Patient/Authorized Representative **Date**

_____

Printed Name of Authorized Representative