COVID-19 Vaccine Acknowledgement & Consent Form

Crawford County Health Department

410 E. Atkinson Pittsburg, Kansas 66762

Phone (620)231-5411

I have been offered or provided, whether accepted or not, a copy of the Privacy Act and "Vaccine Information Statement(s)". I have read, or had explained to me, the information in the Vaccine Information Statement(s). My questions have been answered satisfactorily, and I ask that the vaccine(s) checked below be given to me or the person named below for whom I am authorized to make this request. I consent to this immunization data being provided to the Kansas Immunization Registry for myself or on behalf of the person named below. I also acknowledge that a copy of the Crawford County Health Department Privacy Policy Statement has been made available to me. I agree that the patient's health insurance will be billed for any vaccine & administration fee, and that any portion not covered by this insurance will be the responsibility of you the patient or parent/guardian.

Patient Information (Please Print)

Patient's Legal Name:_____ **Age:**_____ **Birthdate:**_____

Street Address:_____**City:**_____**State:**_____**Zip Code:**_____

Phone Number:_____ **Gender:**_____ **Race:**_____ **Hispanic/Latino: Yes**_____ **No**_____

The following questions will help determine whether the person to be vaccinated can receive the COVID-19 vaccine today.
If there is a "yes" answer to any question, it does not mean you should not be vaccinated. It just means additional questions must be asked.
If a question is not clear, please ask a staff member for further explanation:

COVID-19 Vaccine Screening Questionnaire

Is the person to be vaccinated currently sick?	_____Yes	_____No
Has the person to be vaccinated had a serious reaction to a vaccine in the past?	_____Yes	_____No
Does the person to be vaccinated have a history of severe allergies?	_____Yes	_____No
Does the person to be vaccinated have a bleeding disorder or on blood thinner?	_____Yes	_____No
Is the person to be vaccinated immunocompromised or on a medication that affects the immune system? (steroids, chemotherapy, etc)	_____Yes	_____No
Is the person to be vaccinated currently pregnant or planning to become pregnant?	_____Yes	_____No
Is the person to be vaccinated currently breastfeeding?	_____Yes	_____No
Has the person to be vaccinated received any vaccinations in the past 2 weeks?	_____Yes	_____No
Has the person to be vaccinated previously been diagnosed with COVID-19 and were treated with monoclonal antibodies within the last 90 days?	_____Yes	_____No

I understand that the COVID-19 vaccine I will receive today requires two (2) doses from the same manufacturer to be fully effective. I understand I must return in 21 days of the first dose to receive a second dose of the vaccine.
I consent to administration of the Pfizer COVID-19 vaccination and acknowledge and agree with the following statements:

- I have received the Fact Sheet.
- I have read the Fact Sheet or had it read to me.
- The U.S. Food and Drug Administration (FDA) has authorized the Pfizer Vaccine.
- I understand the known and potential risks and benefits to the Pfizer COVID-19 vaccine and the extent to which such benefits and risks are unknown.
- I acknowledge that I have the option to refuse vaccination and have been informed of any available alternatives to Pfizer COVID-19 vaccine and the risks and benefits of available alternatives
- Recipients who are Pregnant or Breastfeeding: Pregnant and breastfeeding persons were not included in the clinical trials for the Pfizer COVID-19 vaccine. I have discussed the potential risks of COVID-19 infection versus the risk of vaccination with my healthcare provider and have made the informed decision to receive the Pfizer COVID-19 vaccine.
- I have had the opportunity to ask questions which have been answered to my satisfaction.

If you experience an adverse reaction to the COVID-19 vaccine, please contact your primary care provider or go to the nearest emergency department.
If you are experiencing a medical emergency, call 911.

Signature of Patient or Parent/Guardian	Date	Print Name	Relationship

Vaccine	Dose	EXT	Site	Route	VIS Date	Manufacturer/Lot #	Exp Date
COVID-19	1	Rt Lt	Deltoid	IM	12/01/2020	Pfizer:	/ /2021
COVID-19	2	Rt Lt	Deltoid	IM	12/01/2020	Pfizer:	/ /2021

Signature and Title of Person Administering	Date	Signature and Title of Person Administering	Date