Columbia County Health System
1012 S. 3rd St. Dayton, WA 99328
509-382-2531

Pfizer-BioNTech COVID-19 Vaccine Patient Acknowledgment

Patient Name (Last, First): _____ DOB: ____/____/_____

Phone: _____ Mobile Phone: _____Email: _____
(This information will be used to contact you for your second dose reminder.)

Address: _____ City, State, Zip Code: _____

Information collected in this section helps ensure we deliver equitable and patient-centered care:
Sex listed at birth (check one):

Male: ☐	Female: ☐

Gender identity (check one):

Male: ☐	Female: ☐	Non-Binary ☐	Unspecified/Indeterminant: ☐

Ethnicity (Check one):

Hispanic or Latino (Including Spanish, Mexican, Puerto Rican, Cuban, etc. ☐	Not-Hispanic A person not of Spanish culture or origin ☐

Race: (Check all that apply):

Black or African American ☐ White ☐	Asian ☐ American Indian or Alaska Native ☐	Hawaiian or Pacific Islander ☐

Insurance Information:

Insurance company: _____ Are you the primary card holder? Y N

If no, what is the primary card holders name and date of birth? _____

Cardholder ID: _____ Rx Group ID: _____

BIN: _____ PCN: _____

Are you Medicare eligible? Y N If yes, Medicare Part A/B number: _____

If you are not insured and you do not want to pay for administration of the vaccine yourself, you must provide the information below. If you do not provide this information you may be billed for vaccine administration.

> *I do not have any insurance, including but not limited to Medicare, Medicaid, or any other private or government-funded health benefit plan. In order to have your vaccine administration fee paid for by the United States Health Resources & Services Administration's COVID-19 Program for Uninsured Patients please provide (a) a valid Social Security number, or (b) state identification number and state of issuance, or (c) a driver's license number and the state of issuance:* _____

Acknowledgements:

- *I made the choice to get the COVID-19 vaccine on my own and freely. I know I have the option to refuse the vaccine. I ask that the vaccine be given to me, or to the person named above for whom I can make this request. I was given the (Fact Sheet for Vaccine Recipients and Caregivers)* for this vaccine. The fact sheet *has information about side effects and adverse reactions. I read or had read to me the information provided about the COVID-19 vaccine.*
- *I know the Food and Drug Administration (FDA) has authorized the emergency use of this vaccine. I know it is not a fully licensed FDA vaccine. I had the chance to ask questions that were answered to my satisfaction. I now know about the vaccine, alternatives, benefits, and risks, to the extent they are known and unknown at this time.*

- *I know that I must stay in the vaccine area or an area told to me by my health care provider after I receive my immunization so I am near my health care provider if I have any adverse reactions.. If I have a history of severe allergic reaction, (e.g. anaphylaxis), I must stay for 30 minutes. If I do not have a history of severe allergic reaction, I must stay for 15 minutes*

- *I know that if I have a severe allergic reaction, including difficulty breathing, swelling of my face and/or throat, a fast heartbeat, a bad rash all over my body or dizziness and weakness I should call 9-1-1 or go to the nearest hospital. I know I can call my health care provider if I have any side effects that bother me or do not go away.*

- *I was asked to join the V-SAFE program. The program does health checks on the people who get the COVID-19 vaccine. I know I should report vaccine side effects to FDA/CDC Vaccine Adverse Event Reporting System (VAERS) at 1-800-822-7967 or https://vaers.hhs.gov/reportevent.html.*

- *I know I must get two doses of the COVID-19 vaccine and receive the same vaccine each time. I know that with all vaccines there is no promise I will become immune (not get the virus) or that I will not have side effects. I know I may choose to not get the second dose of the vaccine. But if I do not get the second dose, the chance that I will become immune may go down.*

Authorization to Request Payment: *I authorize the organization providing my vaccine to release information and request payment. I certify that the information given by me in applying for payment under Medicare or Medicaid or the HRSA COVID-19 Program for Uninsured Patients, is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.*

Disclosure of Records: *I understand the organization providing my vaccine may be required to or may voluntarily disclose my vaccine-related health information to my primary care physician, my insurance plan, health systems and hospitals, and state or federal registries or other public health authorities, for purposes of treatment, payment or health care operations. I also understand the organization providing my vaccine will use and disclose my health information as described in its Notice of Privacy Practices which I may receive upon request or find on its website. If I am an employee of [insert name of health care provider] I understand that it will keep records of this vaccination for me in [insert name of electronic health record] and may keep my vaccination records in [insert name of health care provider]'s employee occupational health records, to the extent required or permitted by law.*

Patient (or Parent/Guardian/Authorized Representative) Signature: _____ Date: _____

Name of Parent, Guardian or Authorized Representative: _____ Date: _____

If you are signing on behalf of the patient, you are stating that you are authorized to make the required decisions on behalf of the patient.

All sections below are for official use only:

Vaccine Administration Information for Immunizer:

Administration date: _____ Administration time: _____

CVX (Product): _____

Dose number: _____

IIS Recipient ID: _____

IIS vaccination event ID: _____

Lot number: _____

Unit of Use MVX (Manufacturer): _____

Sending organization: _____

Vaccine administering provider suffix: _____

Vaccine administering site on the body: Left deltoid ☐ Right deltoid ☐ Other ☐ (indicate location) _____

Vaccine expiration date: _____

Vaccine route of administration: _____

Vaccination series complete (date): _____

Fact Sheet for Vaccine Recipients and Caregivers version date: _____

Pre-Vaccination Form for Pfizer-BioNTech COVID-19 Vaccine

For vaccine recipients:

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

Patient Name _____

Age _____

	Yes	No	Don't know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine? If yes, which vaccine product? ☐ Pfizer ☐ Another product _____			
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?			
• Was the severe allergic reaction after receiving a COVID-19 vaccine?			
• Was the severe allergic reaction after receiving another vaccine or another injectable medication?			
4. Do you have a bleeding disorder or are you taking a blood thinner?			
5. Have you received passive antibody therapy as treatment for COVID-19?			

Form completed by _____ **Date** _____

Form reviewed by _____ **Date** _____

Pre-Vaccination Form for Pfizer-BioNTech COVID-19 Vaccine

Information for Healthcare Professionals about the Pre-Vaccination Form for Pfizer-BioNTech COVID-19 Vaccine.

For additional information on COVID-19 vaccine recommendations, see:
https://www.cdc.gov/vaccines/covid-19/info-by-product/pfizer/clinical-considerations.html

For additional information on ACIP general recommendations, see:
https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/index.html

Are you feeling sick today?

There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events. However, as a precaution with moderate or severe acute illness, all vaccines should be delayed until the illness has improved. **Mild illnesses (e.g., upper respiratory infections, diarrhea) are NOT contraindications to vaccination.** Do not withhold vaccination if a person is taking antibiotics. **Vaccination of persons with current SARS-CoV-2 infection should be deferred until the person has recovered from acute illness and they can discontinue isolation.** While there is no minimum interval between infection and vaccination, current evidence suggests reinfection is uncommon in the 90 days after initial infection. Persons with documented acute SARS-CoV-2 infection in the preceding 90 days may delay vaccination until near the end of this period, if desired.

Have you ever received a dose of COVID-19 vaccine?

Two doses of the same COVID-19 vaccine product are recommended. Check medical records, immunization information systems, and vaccination record cards to help determine the initial product received. Those who received a trial vaccine should consult with the trial sponsors to determine if it is feasible to receive additional doses.

Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?

Allergic reactions, including severe allergic reactions, NOT related to vaccines or injectable therapies (e.g., food, pet, venom, environmental, or latex allergies; oral medications) are NOT a contraindication or precaution to vaccination with currently authorized COVID-19 vaccine. HOWEVER, individuals who have had severe allergic reactions to something, regardless of cause, **should be observed for 30 minutes after vaccination.** All other persons should be observed for 15 minutes.

Was the severe allergic reaction after receiving a COVID-19 vaccine?

History of severe allergic reaction (e.g., anaphylaxis) to a previous dose or component of the COVID-19 vaccine product being offered is a contraindication to that COVID-19 vaccine.

Was the severe allergic reaction after receiving another vaccine or another injectable medication?

A history of mild allergic reaction to a vaccine or injectable therapy is not a precaution to vaccination. History of severe allergic reaction (e.g., anaphylaxis) to another vaccine or a component of another vaccine OR anaphylactic reaction to any other injectable medication is a **precaution to currently authorized COVID-19 vaccine.** Vaccine may be given, but counsel patients about unknown risks of developing a severe allergic reaction and balance these risks against the benefits of vaccination. These individuals should be observed for 30 minutes after vaccination.

Do you have a bleeding disorder or are you taking a blood thinner?

COVID-19 vaccine may be given to these patients, if a physician familiar with the patient's bleeding risk determines that the vaccine can be administered intramuscularly with reasonable safety. ACIP recommends the following technique for intramuscular vaccination in patients with bleeding disorders or taking blood thinners: a fine-gauge needle (23-gauge or smaller caliber) should be used for the vaccination, followed by firm pressure on the site, without rubbing, for at least 2 minutes.

Have you received passive antibody therapy as treatment for COVID-19?

Based on the estimated half-life of monoclonal antibodies or convalescent plasma as part of COVID-19 treatment, as well as evidence suggesting that reinfection is uncommon in the 90 days after initial infection, **vaccination should be deferred for at least 90 days,** as a precautionary measure until additional information becomes available, to avoid interference of the antibody treatment with vaccine-induced immune responses.

»Considerations

Immunocompromise is not a contraindication to current COVID-19 vaccine, including those with cancer, leukemia, HIV/AIDS and other immune system problems or taking medication that affects their immune systems. However, patients should be informed that the vaccine might be less effective than in someone who is immunocompetent.

Pregnancy is not a contraindication to current COVID-19 vaccine. While there are currently no available data on the safety of COVID-19 vaccines in pregnant people, studies and results are expected soon. Pregnant people may choose to get vaccinated. Observational data demonstrate that while the absolute risk is low, pregnant people with COVID-19 have an increased risk of severe illness.

Lactation is not a contraindication to current COVID-19 vaccine. Lactating people may choose to be vaccinated. There is no data available for lactating people on the effects of mRNA vaccines.

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Notes about this form:

- ***This form should only be provided to a patient if it is accompanied by the Fact Sheet for Vaccine Recipients and Caregivers*** https://www.cvdvaccine.com/***.***
- This form should only be used by clinicians well versed in the CDC's provider education materials who are able to counsel patients who answer "yes" to the screening questions or make referrals for counseling for those patients.
- This form is intended as a resource. It is not a mandatory form.
- This form was developed based on the best available information at the time it was created. Its accuracy is not guaranteed. Organizations and individuals choosing to use this form should do so in consultation with their own clinicians and attorneys.
- This form is subject to update without notice.
- For convenience, some elements in this form may be pre-recorded in electronic health records or other databases.
- Resources used in creating this form:
    - COVID-19 Vaccination Training Programs and Reference Materials for Healthcare Professionals for information about screening questions and *Fact Sheet for Vaccine Recipients and Caregivers* https://www.cdc.gov/vaccines/covid-19/downloads/COVID-19-Clinical-Training-and-Resources-for-HCPs.pdf
    - Global Information About Pfizer-BioNTech COVID-19 Vaccine (also known as BNT162b2): https://www.cvdvaccine.com/
    - V-Safe Program; https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/vsafe.html
    - COVID-19 Vaccination Communication Toolkit: https://www.cdc.gov/vaccines/covid-19/health-systems-communication-toolkit.html
    - Washington State's COVID-19 Vaccine Plan for vaccine reporting requirements. https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/WA-COVID-19-Vaccination-Plan.pdf
    - For Demographic Information:
        - Washington State CHARS Manual: https://www.doh.wa.gov/Portals/1/Documents/5300/CHARSManual-UB04-5010.pdf
        - Race Ethnicity Language Data Collection Best Practices: http://forces4quality.org/af4q/download-document/6011/Resource-validated_final_rel_data_collection_best_practice_guidelines_updated_11-28.pdf
        - Collecting Sexual Orientation and Gender Identity Information: https://www.cdc.gov/hiv/clinicians/transforming-health/health-care-providers/collecting-sexual-orientation.html