Pfizer COVID-19 VACCINE ADMINISTRATION RECORD

I have been given a copy and read or have had explained to me the information in the Emergency Use Authorization (EUA) of the Pfizer-Biontech COVID-19 Vaccine to prevent Coronavirus disease 2019 revised 12/2020. I understand the benefits and risks of the Pfizer-Biontech vaccine and request that the immunization be given to me or the person named below for whom I am authorized to make this request. I agree to remain at the vaccination site for 15 minutes following the immunization. I also understand that the information collected on this form will be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with the patient to assure continuation of health care services.

Patient's Name (Last, First, Middle Initial)	Date of Birth	***Age***	☐ Male ☐ Female
Maiden Name:	Other last names you've had:		
Telephone Number	County		
Address	City	State	Zip
Ethnicity (check one): ☐ Hispanic ☐ Non-Hispanic	Race (check one) ☐ African American ☐ Asian ☐ Native American ☐ White ☐ Other		

Questions for person receiving vaccine:	Yes	No
Are you sick today?		
Have you had a severe allergic reaction to a previous vaccination?		
Have you had a severe allergic reaction to any of the vaccine components?		
Have you received a COVID-19 vaccine? If yes, date Brand:		
Have you received any vaccine in the past 14 days?		
*Have you had an immediate allergic reaction of any kind to a vaccine or injectable therapy or a history of anaphylaxis due to any cause? (you will be asked to stay for 30 min. after vaccination)		
*Are you immunocompromised or on a medication that affects your immune system?		
*Are you pregnant or breastfeeding?		

By my signature below, I consent to allow Buffalo County Public Health Department and its staff to bill my insurance company.

Please provide all insurance information from both sides of the Insurance Card. If you have Medicare, we must collect both your supplemental insurance (if you have one) as well as your Medicare information. If your insurance does not include a number listed below, please leave it blank.

Medicare#: ___________________________________

If you are not on Medicare OR have a Medicare Supplemental/Advantage, please include that information here:

Insurance Company:___________________________________ Mailing Address:_____________________________________

ID#:___________________________ Group#:__________________ Payer ID/EDI#:_____________________

Type of Insurance: ☐ Commercial ☐ HMO ☐ Medicare ☐ Medicare Advantage ☐ Medicare Supplmntl ☐ Badgercare

Signature of person to receive vaccine or authorized person: X ____	Date:

-- **For Office Use Only** --

Vaccine	Site	Manufacturer	Lot Number	Date	Vaccinator
COVID-19	LD RD	Pfizer COVID-19			Taylor Bloom, RN JoAnn Buchholz, RN James Ede, RN Jacqueline Traun, RN Josafine Knauber, RN Ashley Goss, RN Amy Marinelli, RN Other:

Signature and Title of Vaccine Administrator: ____