Recipient Name: First_____Middle_____Last_____

Date of Birth _____/_____/_____ **Recipient Email Address:** _____ ☐ No email

Home Phone Number: _____**Mobile Phone Number:** _____

Address: _____ **City:** _____

Zip Code: _____ **County:** _____**State:** _____

Best way to contact you: ☐ SMS/Text Message ☐ Email ☐ Both ☐ None

Recipient Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ☐ Unknown

Recipient Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Recipient Gender: ☐ Male ☐ Female ☐ Other ☐ I do not want to specify

Preferred Language: ☐ English ☐ French ☐ Spanish ☐ Other: _____ ☐ Decline to state

Disabilities: ☐ Not Disabled ☐ Cancer ☐ Cognitive (Psychological or Psychiatric) ☐ Neurological ☐ Physical (Mobility) ☐ Respiratory ☐ Sensory (Vision or Hearing) ☐ Other (Please Specify: _____)

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.

1. Are you feeling sick today? **__Yes __No**

2. Have you ever received a dose of COVID-19 vaccine? **__Yes __No __Don't know**
* if yes, which vaccine product did you receive? __ Pfizer-BioTech __ Moderna
__ Janssen (Johnson & Johnson) __ Another product: _____
* have you received a complete COVID-19 vaccine series? **__Yes __No**
(i.e. one dose Janssen or 2 doses of an mRNA vaccine (Pfizer-BioTech, Moderna)
* did you bring your vaccination record card or other documentation? **__Yes __No**

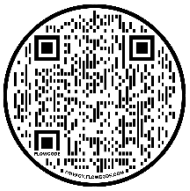
3. Have you ever had an allergic reaction to: *(This would include severe reaction [e.g. anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that cause hives, swelling, or respiratory distress, including wheezing.)*
* a component of a COVID-19 vaccine, including either of the following: **__Yes __No __Don't know**
*polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures.
* polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids.
* a previous dose of COVID-19 vaccine **__Yes __No __Don't know**

4. Have you ever had an allergic reaction to another vaccine (*other than COVID-19 vaccine)* or an injectable medication? (*This would include severe reaction [e.g. anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that cause hives, swelling, or respiratory distress, including wheezing.)* **__Yes __No __Don't know**

5. Check all that apply to you:
Have a history of pericarditis **__Yes**
Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies **__Yes**
Had COVID-19 disease and was treated with monoclonal antibodies or convalescent serum **__Yes**
Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection **__Yes**
Have a bleeding disorder **__Yes**
Take a blood thinner **__Yes**
Have a weakened immune system (i.e. HIV infection, cancer) or take immunosuppressive drugs or therapies **__Yes**
Have received dermal fillers **__Yes**

PLEASE FLIP TO BACK SIDE FOR SIGNATURE

I certify that I am able to consent for this COVID19 vaccine against this communicable disease or I am the parent or legal guardian of the above-named patient if they are a minor. I consent to receive the vaccine and for my demographic and health condition information to be shared with the COVID-19 Management System (CVMS) as required. I have received a copy of the Emergency Use Authorization Fact Sheet on the Pfizer COVID-19 vaccine (QR codes 5-11yo on top, 12yo+ on bottom). I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes (or more in specific cases) after administration for observation. If I experience a severe reaction after leaving the office, I will call 911 or go to the nearest hospital.



I authorize payment from private Insurance or Medicare/Medicaid to be made on my behalf to the licensed healthcare provider administering the vaccine for services provided. I understand that my signature below will serve as legal "signature on file" for purposes of filing insurance/Medicaid claims and payment of benefits to Sandhills Pediatrics. **THE COVID VACCINES ARE FREE TO EVERYONE, REGARDLESS OF WHETHER YOU HAVE PRIVATE OR GOVERNMENT INSURANCE OR NO INSURANCE AT ALL**. If you are not an existing Chapel Hill Children & Adolescents' Clinic patient, we need a copy of your insurance card so we can bill your insurance (No out of pocket cost to you by Federal Law!)

Signature _____Date _____

Print name_____ (**Parent/guardian must sign if <16yo**)

Site of Injection: ☐ Right Deltoid, IM ☐ Left Deltoid, IM ☐Other_____ ☐ 1st dose ☐ 2nd ☐ 3rd ☐ Booster

Administration Date: _____/_____/_____ **Time:** _____ Pfizer COVID19 vaccine (COMIRNATY)

Lot #: _____**Exp:** _____/_____/_____ **Checklist Reviewed and Vaccine administered by:**

___ Lewis ___ Gaitan ___ Simpson ___ Carrillo ___ Womack ___Soto ___Walker

___ Windham ___Minozzi ___Fowler ___Brookhart ___Delgado ___Matijasevic ___ Other: _____