



106 N. Jackson St, Suite 103, Mt. Pleasant, IA 52641

# PFIZER COVID-19 Vaccine Administration Record

I am:  6 months to 4 years old  5-11 years old  12 years or older

I am here for my:  1<sup>st</sup> Dose  2<sup>nd</sup> Dose  3<sup>rd</sup> Dose (if applicable)  Booster

Date 1st dose administered: \_\_\_\_\_ Circle brand: Pfizer Moderna \_\_\_\_\_  
Other

Date 2nd dose administered: \_\_\_\_\_ Circle brand: Pfizer Moderna \_\_\_\_\_  
Other

Date last booster administered: \_\_\_\_\_ Circle brand: Pfizer Moderna \_\_\_\_\_  
Other

### Section 1: Vaccine Recipient Information (Please Print)

Recipient Name: \_\_\_\_\_  
Last First M.I.

Any other last names vaccination records might be under: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Phone Number: \_\_\_\_\_  Male  Female

### Section 2: Screening for Vaccine Eligibility

Are you immunocompromised (weakened immune system)?  Yes  No

Have you ever had a severe allergic reaction to any vaccination?  Yes  No

If you have previously received the COVID-19 vaccine, did you experience hives, wheezing/respiratory distress, or anaphylaxis within 4 hours of receiving your shot?  Yes  No  N/A

### Section 3: Consent

I have read or have had explained to me the information provided in the Emergency Use Authorization (EUA) Factsheet or Vaccine Information Statement about COVID-19 vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of COVID-19 vaccine and ask that the vaccine be administered to me or to the person named above for whom I am authorized to make this request. **I understand the person receiving the COVID-19 vaccine should remain in the clinic for 15 minutes after the vaccination.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Links to the COVID-19 Vaccine EUA Fact Sheets for Recipients are referenced on the CDC handout you received today and hard copies of the fact sheets are available upon request.*

**Healthcare Provider Use Only**

Date Vaccine Administered: \_\_\_\_\_ Injection Site (Deltoid):  Left  Right

Manufacturer: \_\_\_\_\_ Lot # \_\_\_\_\_ Exp: \_\_\_\_\_ Administered by: \_\_\_\_\_

**SEE BACK FOR INSURANCE INFORMATION**

# Insurance Billing

I, the undersigned, certify that the information given by me in applying for payment under the private insurance I provided, is correct. I authorize release of all records required to act on their request and request that payment of authorized benefits be made on my behalf or all who may be covered by this insurance. I authorize such insurance to make payment directly to Henry County Public Health.

Note: If your insurance does not pay, you WILL NOT be billed for any COVID-19 vaccine expense.

Insurance Company Name: \_\_\_\_\_

Insurance #: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Sex: M\_\_\_\_ F\_\_\_\_

Date of Birth of Policy Holder: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_