COVID-19 Coronavirus

Douglas County Health Department

******ARE YOU ALLERGIC TO LATEX? TELL NURSE IF YOU ARE! ******

PRINT name as shown EXACTLY on Medicare Card: (If applicable)

NAME: _____ ____ _____ **SEX:** M F
FIRST MI LAST

DATE OF BIRTH: ____/____/____ ____ **PRIMARY PHONE #:** ____-____-____
Month Day Year **Age**

_____ _____ _____ _____
STREET ADDRESS **CITY** **STATE** **ZIP CODE**

- I have read or have had explained to me the information in the Fact Sheet about the Emergency Use Authorization of the **Pfizer Covid-19 vaccine**. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the Covid-19 vaccine and ask that the vaccine be given to me or the person named below for whom I am authorized to make this request.
- I, the undersigned, voluntarily agree to have the Covid-19 vaccine given to me (or the person named above). I have completed the pre-vaccination form. The person receiving this vaccine is in good health at this time and is not allergic to latex I understand that a physician consult is necessary prior to taking the vaccine for persons who have a history of bleeding disorder or on a blood thinner or have ever had a serious allergic reaction or other problems after getting any vaccination.
- I consent to allow information on this form, as well as the patient registration form, to be entered as necessary in the Illinois Immunization Registry (ICARE) and LCHD's electronic billing system.
- I have been provided information on V-Safe, a safety monitoring smartphone-based tool managed by CDC, and VaxText Messaging service for second-dose reminders.
- I will not hold the Douglas County Health Dept. or the nurse giving the vaccine responsible for any adverse reaction that may result from this vaccination.
- I authorize the release of any information necessary to process a Medicare, Medicaid or health insurance claim if applicable. I request payment of benefits to Douglas County Health Dept.
- I have been provided with Notice of Privacy Practices.

SIGNATURE:_____ **DATE:**_____

FOR NURSE USE ONLY: Fact Sheet Provided: ___ **Yes** ___ **No**

Vaccine Information: 2nd Dose Required: ___ **Yes** ___**No**

Manufacturer: Pfizer **Lot #:**
Dosage: 0.3ml **Expiration:**

Site: **Left Deltoid** **Right Deltoid**

Nurse Signature: _____ **Date/Time Administered:** _____

For DCHD Use Only:
Name Printed Clearly by Employee/Volunteer: _____