Penn Highlands Huntingdon

HW-228

Patient's Name:_____

DOB_____

CONSENT FOR COVID VACCINATION/VACCINE ADMINISTRATION RECORD

I _____ have read or had explained to me the information about the diseases and
(Person Authorized to Consent)

the vaccine as listed below. I have had the opportunity to ask questions which were answered to my satisfaction. This vaccine has been covered under emergency use authorization for active immunization to prevent coronavirus disease 2019 (COVID-19) caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) for those ages 16 years and older (Pfizer) or 18 years and older (Moderna). There is not an FDA approved vaccine to prevent COVID-19. I have read and understand the "Fact Sheet for Recipients and Caregivers" provided. I understand that I should remain in the waiting area for a minimum of 15 minutes for observation in case there is an adverse reaction. I understand the benefits and risk of this vaccine and request it be given:

_____ _____ _____

(Name of Patient – First / Middle / Last) **Patient Signature** **Date/Time**

Address: _____ **Phone:** _____

❑ **Female** ❑ **Male**

Race: ❑ Aleut ❑ Arabian ❑ Asian Indian ❑ Black ❑ Cambodian ❑ Chinese ❑ Eskimo ❑ Filipino
❑ Guamian ❑ Hawaiian ❑ Indian ❑ Japanese ❑ Korean ❑ Laotian ❑ Other Asian or Pacific Islander
❑ Samoan ❑ Thailander ❑ Unknown ❑ Vietnamese ❑ White ❑ Other: _____ ❑ Prefer not to answer

Ethnicity: ❑ Non-Hispanic ❑ Cuban ❑ Mexican ❑ Puerto Rican ❑ Unknown ❑ Unknown Hispanic
❑ South or Central American ❑ Other: _____ ❑ Prefer not to answer

Vaccine Administration Record

EUA Patient Education Document Date	Product (Manufacturer)	Lot#	Exp Date	Dosage	Administration Site
February 25, 2021 □ Given	Pfizer/BioNTech COVID-19 Vaccine (SARS-CoV-2 Virus) 0.3 ml (30 mcg) Intramuscular			□ First Dose □ Second Dose	□ Left Deltoid □ Right Deltoid
March 26, 2021 □ Given	Moderna COVID-19 Vaccine (SARS-CoV-2 Virus) 0.5 ml (100 mcg) Intramuscular			□ First Dose □ Second Dose	□ Left Deltoid □ Right Deltoid

Emergency Use Authorization Document for Recipients and Caregivers (Pfizer):
https://www.fda.gov/media/144414/download

Emergency Use Authorization Document for Recipients and Caregivers (Moderna):
https://www.fda.gov/media/144638/download

_____ _____ _____

Vaccinator Signature Date Time

If Employed by Penn Highlands Healthcare, please check primary location

☐ **PHH BROOKVILLE** ☐ **PHH CLEARFIELD** ☐ **PHH DUBOIS** ☐ **PHH ELK** ☐ **PCM**

☐ **PHCNI** ☐ **JEFFERSON MANOR** ☐ **PH HUNTINGDON** ☐ **PH TYRONE** ☐ **HELPMATES**

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Screening questions: Please complete the following checklist prior to vaccine administration.

Question	Answer
Have you had symptoms of illness today?	☐ Yes ☐ No ☐ Unknown
Have you had a positive COVID-19 test in the last 10 days or been advised by a health care professional or the state Department of Health to quarantine in the past 10 days due to exposure?	☐ Yes ☐ No ☐ Unknown
Have you been treated with a monoclonal antibody or convalescent plasma in the past 90 days for treatment of COVID-19?	☐ Yes ☐ No ☐ Unknown
Are you pregnant?	☐ Yes ☐ No ☐ Unknown
Are you breastfeeding?	☐ Yes ☐ No ☐ Unknown
Have you had a severe reaction (hives, difficulty breathing, or anaphylaxis) to any vaccine or injection?	☐ Yes ☐ No ☐ Unknown
Have you had a vaccine in the previous 14 days?	☐ Yes ☐ No ☐ Unknown
Do you have active cancer, leukemia, HIV/AIDS, an autoimmune disease, radiation treatments, or a condition that weakens the immune system?	☐ Yes ☐ No ☐ Unknown
Have you recently taken a medicine that affects your immune system (example: prednisone, cortisone, steroids, or medications for cancer or transplant)?	☐ Yes ☐ No ☐ Unknown
Do you have a history of allergic reaction or allergies to polyethylene glycol or polysorbate?	☐ Yes ☐ No ☐ Unknown

Which Dose?

☐ 1st Dose ☐ 2nd Dose

VACCINE REGISTRATION

DATE OF VACCINE: _____

PATIENT LEGAL NAME: _____

DATE OF BIRTH: _____

FULL ADDRESS: Street_____

City_____ **State/Zip**_____

TELEPHONE #: _____

LEGAL IDENTIFIED SEX:_____ **SOCIAL SECURITY #:**_____

ETHNICITY (CHOOSE ONE): ☐ Hispanic ☐ Non-Hispanic ☐ Unknown ☐ Prefer not to answer

Race: ☐ Aleut ☐ Arabian ☐ Asian Indian ☐ Black ☐ Cambodian ☐ Chinese ☐ Eskimo
☐ Filipino ☐ Guamian ☐ Hawaiian ☐ Indian ☐ Japanese ☐ Korean ☐ Laotian
☐ Other Asian or Pacific Islander ☐ Samoan ☐ Thailander ☐ Vietnamese ☐ White
☐ Other: _____ ☐ Prefer not to answer

PCP or PERSONAL PHYSICIAN:_____

PLEASE BRING YOUR PHOTO ID AND INSURANCE CARDS.
HAVE YOUR CARDS READY FOR REGISTRATION
STAFF TO COPY.
IF YOU HAVE MEDICARE OR MEDICARE ADVANTAGE PLAN,
YOU NEED TO BRING YOUR RED, WHITE, AND BLUE,
PAPER MEDICARE CARD.