PFIZER-BIONTECH COVID-19 VACCINE REGISTRATION AND CONSENT FORM

Freehold Area Health Department

Please print clearly

FREEHOLD AREA HEALTH DEPARTMENT
Working Hard to Keep You Healthy
732-294-2060

NAME (last, first)		EMAIL	
STREET			
CITY	STATE	ZIP	
PHONE	DATE OF BIRTH	AGE	
GENDER: □ FEMALE □ MALE ETHNICITY: □ HISPANIC or LATINO □ NOT HISPANIC □ PREFER NOT TO SPECIFY	RACE (circle one)	American Indian or Alaska Native Black or African American Native Hawaiian or Other Pacific Islander Prefer not to specify	White Asian Other
MEDICARE Part B #	Health Insurance Company: Group #	Policy #	

Please Answer the Following Questions:	**Yes**	**No**	FAHD
1. Is the person to be vaccinated feeling sick today?	☐	☐	
2. Has the person to be vaccinated previously received a dose of COVID-19 vaccine? If yes, date of last vaccination and which vaccine product did you receive? **Date Rec'd**: _____ **Manufacturer/Brand**: _____	☐	☐	
3. Has the person to be vaccinated ever had a severe allergic reaction (e.g. anaphylaxis) to: (This would include a severe allergic 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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
• A component of a COVID-19 vaccine including either of the following:			
o Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures	☐	☐	
o Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids.	☐	☐	
• A previous dose of COVID-19 vaccine.	☐	☐	
• A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction.	☐	☐	
4. Has the person to be vaccinated ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic 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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)	☐	☐	
5. Has the person to be vaccinated ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, or any vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies.	☐	☐	
6. Has the person to be vaccinated received any other vaccines in the past 14 days?	☐	☐	
7. Has the person to be vaccinated ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	☐	☐	
8. Has the person to be vaccinated received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐	☐	
9. Is the person to be vaccinated have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐	☐	
10. Does the person to be vaccinated have a bleeding disorder or on blood thinners?	☐	☐	
11. Is the person to be vaccinated pregnant or breastfeeding?	☐	☐	
12. Does the person to be vaccinated have dermal fillers?	☐	☐	
13. If you answered yes to any questions above, was COVID19 vaccination administration discussed and recommended by your health care provider?	☐	☐	

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- **I** (or the individual on whose behalf I am signing) **have read or had explained to me by the Freehold Area Health Department staff** the attached information about COVID-19 and the COVID-19 vaccine. I (or the individual on whose behalf I am signing) had an opportunity to ask questions about COVID-19 and the vaccine which were answered to mysatisfaction, and I (and the individual on whose behalf I am signing) am 18 years of age or older. I have been informed of the Notice of Privacy Practices. If signing on behalf of someone else, I am authorized to sign on that individual's behalf.
- I (or the individual on whose behalf I am signing) am not allergic to Epinephrine (adrenalin) the drug used to counteract an allergic reaction to a COVID-19 vaccine. I (or the individual on whose behalf I am signing) am not allergic to latex. I (or the individual on whose behalf I am signing) do not currently have a fever or the symptoms of an acute infection.
- I (or the individual on whose behalf I am signing) understand that the Pfizer COVID-19 immunization requires two injections/doses, and I (or the individual on whose behalf I am signing) understand that receipt of the vaccine does not completely protect me (or the individual on whose behalf I am signing) against COVID-19 or other illnesses that resemble COVID-19. I (or the individual on whose behalf I am signing) further understand that if I (or the individual on whose behalf I am signing) have a condition of (or am undergoing treatment which causes) immune-suppression (the reduction in my body's ability to fight infection and illness), the effectiveness of the vaccine in prevention COVID-19 may be diminished. I (or the individual on whose behalf I am signing) believe I understand the risks and benefits of the vaccine.
- I (or the individual on whose behalf I am signing) understand that the vaccinated individual will be enrolled in the New Jersey Immunization Information System (NJIIS) pursuant to State of New Jersey Executive Order #207. I (or the individual on whose behalf I am signing) may request in writing to withdraw from NJIIS after completing the full course of COVID-19 vaccination and said removal will take effect 30-days after the Public Health Emergency has expired.
- **I (or the individual on whose behalf I am signing) understand that it is my responsibility to remain in the vaccination area for 15 minutes after I (or the individual on whose behalf I am signing) receive the vaccine, in case I (or the individual on whose behalf I am signing) experience a reaction.**
- I (or the individual on whose behalf I am signing) agree to receive the COVID-19 vaccine, and I (or the individual on whose behalf I am signing) hereby release **the Township of Freehold, Township of Wall, Borough of Freehold, Health Department, and their employees, servants, representatives, officers, and agents (together, the "Indemnitees")** from any liability for giving me (or the individual on whose behalf I am signing) the COVID-19 vaccination. I (or the individual on whose behalf I am signing) agree to indemnify, defend, and hold the indemnities harmless from any claim made by any person, (including the individual on whose behalf I am signing).
- **My signature (or the individual's signature on whose behalf I am signing) on this form means that all of the information provided in the Registration and Consent Form are true to the best of my knowledge. I (or the individual on whose behalf I am signing) understand that this form and my signature below are binding on me and my heirs, successors, and personal and legal representatives as well as those of the person on whose behalf I am signing. If I am not the person being vaccinated. I warrant that I have the authority to give this consent for the person to be vaccinated.**

Signature:_____ **Date**: _____

Printed Name: _____

Relationship to person to be vaccinated (check one): SELF____PARENT_____GUARDIAN_____MEDICAL POWER OF ATTORNEY_____

OFFICIAL USE ONLY

Vaccination Site: ☐ Right Deltoid ☐ Left Deltoid

Manufacturer: Pfizer
Lot Number
Exp. Date:

Clinic Location:_____ **EUA Fact Sheet Publication Date**: **Date Given**: _____

Vaccine Administered By:_____ **Date**: _____