Somerset County Department of Health – COVID-19 Vaccination

Date:					Right Arm	Left Arm
First Name						
Last Name						
Date of Birth	Month		Day		Year	
Gender	☐ Male	,	☐ Female			
Race	□ As □ Bla □ Na □ W □ Ot	ian ack or A ative Ha hite her Rac	Indian or Ala African Ameri awaiian or ot ce ot to Specify	ican		
Address						
City						
State						
Zip						
Phone Number	Area Code	Numbe	er			
Ethnic Group	☐ Hispanic or Latino☐ Not Hispanic☐ Prefer Not to Specify					
Email Address						
COVID-19 Vaccine Dose	☐ First Dose Manufacturer &		econd Dose	□ Thir	d (Additional) □ Booster

Pfizer Pediatric: 6 months - 4 years



Prevaccination Checklist for COVID-19 Vaccination



	Name							
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.						No	Don't know	
1.	How old are you?							
2. Are you feeling sick today?								
3.	Have you ever received a dose of COVID-19 vaccine? • If yes, which vaccine product(s) did you receive? □ Pfizer-BioNTech □ Moderna □ Janssen (Johnson)	& Johnson)	☐ Another Product					
	How many doses of COVID-19 vaccine have you received?							
	Did you bring your vaccination record card or other documentation?							
4. Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? This would include, but not limited to, treatment for cancer, HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], or moderate or severe primary immunodeficiency.								
5. Have you received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?								
 6. Have you ever had an allergic reaction 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 caused hives, swelling, or respiratory distress, including wheezing.) A component of a COVID-19 vaccine A previous dose of COVID-19 vaccine 								
7.	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 caused hives, swelling, or respiratory distress, including wheezing.)							
8.	Check all that apply to you:							
	☐ Have a history of myocarditis or pericarditis	history of thrombosis withome (TTS)	throm	boc	ytope	nia		
	☐ Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?	☐ Have a history of Guillain-Barré Syndrome (GBS)						
	☐ History of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparininduced thrombocytopenia (HIT)		☐ Have a history of COVID-19 disease within the past 3 months?					

Form reviewed by

Date

Somerset County COVID-19 Vaccination Site

Parental/Guardian Consent form for Pfizer COVID-19 Immunization

- 1. I am the legal parent/guardian of the below named minor.
- 2. I was given a copy of the FDA's Fact Sheet for Recipients and Caregivers in connection with the Emergency Use Authorization (EUA) for the Pfizer-BioNTech COVID-19 Vaccine. I have read the Fact Sheet and understand the risks associated with the vaccine.
- 3. I acknowledge that I, along with the minor named below, have the option to either accept or refuse administration of the Pfizer-BioNTech COVID-19 Vaccine.
- 4. I authorize administration of the Pfizer-BioNTech COVID-19 Vaccine to the minor named below. By signing this waiver, I acknowledge that my child is 6 months to 4 years old.

Parent/Guardian

Printed Name:					
Signature:					
Relation to Minor Named Below:					
Date Authorized:					
Minor Authorized to Receive Vaccine					
Printed Name:					
Date of birth:					