Public Health
Prevent. Promote. Protect.
Tuscarawas County Health Department

TUSCARAWAS COUNTY HEALTH DEPARTMENT

2023-2024 COVID-19 Vaccine-Pfizer

PLEASE PRINT

Information needed for the person who will be receiving the vaccine:

Last Name: _____ First Name: _____ MI_____
Date of birth: _____ SSN: _____ Age: _____ Sex: _____
Address: _____
City: _____ County: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____

Insurance Information

Subscriber's Name: _____ Relationship to the patient: _____
Subscriber's DOB: _____ Subscriber's SSN: _____

For Patients Under 18 Years Old:

Parent/Guardian Name: _____ DOB: _____ SSN: _____

PATIENT QUESTIONS – ANSWER THE DAY OF VACCINATION

Have you had any type of vaccine in the last two weeks? ☐ No ☐ Yes
Have you ever had a severe allergic reaction to a vaccine or any injection in the past? ☐ No ☐ Yes
Have you tested positive for COVID-19 or had a doctor tell you that you had COVID-19 in the last 9- days?
☐ No ☐ Yes
Have you received antibody therapy (monoclonal or convalescent plasma) for COVID-19 in the last 3 months? ☐ No ☐ Yes
Do you have any serious health conditions (often called co-morbidities)? ☐ No ☐ Yes
Do you have a weakened immune system (i.e., from HIV or cancer) or are you on immunosuppressive drugs? ☐ No ☐ Yes
Do you have a bleeding disorder or are you taking a blood thinner? ☐ No ☐ Yes
Are you pregnant or breastfeeding? ☐ No ☐ Yes
Do you feel sick today? ☐ No ☐ Yes
Have you received a COVID-19 vaccine in the last 12 months? ☐ No ☐ Yes

Consent/Notice of Privacy

By signing below, I understand that eligibility for coverage by my insurance company cannot be determined at this time. I understand that the services provided today may not be covered by my insurance company. If it is determined that I am not eligible for coverage and no benefits exist for my claim, I understand that I will be responsible for payment of all services provided.

I have received information concerning 2023-2024 COVID -19 vaccines. I was given a chance to ask questions about the 2023-2024 COVID-19 vaccines. I understand the benefits/risks of the vaccine. I ask the influenza and/or pneumonia vaccine be given to me or to the person named on this form for whom I am authorized to request. I have been offered and/or received a copy of the Notice of Privacy Practices, confirmed by my signature below.

Patient/Parent/Guardian Signature: _____ Date: _____

TCHD Staff will complete this section.

CIRCLE: PRIVATE VFC 317

	PFIZER 6M-4Y	PFIZER 5Y-11Y	PFIZER 12+
Vaccine Manufacturer			
Vaccine Lot Number			
Expiration Date, if needed			
Site of Administration			
Signature of Vaccine Administrator			

VFC ELIGABILITY

VFC ONLY: The patient named above qualifies for immunization through the VFC program because he/she or his/her parent/guardian states the child is 18 years of age or younger and:
_____is Medicaid eligible or has Medicaid.
_____is uninsured (does not have private insurance/self-pay)
_____is an American Indian or Alaskan Native
_____Health insurance does not cover vaccines (only at federal and rural health centers)
_____***The patient does not qualify for immunizations through VFC program because he/she has health insurance that pays for vaccines.***

ADULT 317 ONLY:
____Uninsured
____Underinsured: *Name of Insurance*_____ *Phone number*_____
*Verified requested vaccine is not covered:*_____

9/22/23AK