Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, California 93514

Patient Last Name: _____

Pfizer-BioNTech COVID 19 Vaccine Consent and Disclosure to CAIRS Authorization

Patient Name (Print legibly): _____

Date of Birth: _____

Address: Street or PO Box _____

City: _____ **State:** _____ **Zip Code:** _____

Race select all that apply:
☐American Indian or Alaska Native
☐Asian
☐Native Hawaiian or other Pacific Islander
☐Black or African American
☐White
☐Other Race

Ethnicity:
☐Not Hispanic or Latino
☐Hispanic or Latino

I have reviewed the "Emergency Use Authorization (EUA) of the Pfizer-BioNtech Covid-19 Vaccine to Prevent Coronavirus Disease 2019 (Covid-19) in Individuals 16 Years of Age and Older" and the "CDC Pre-Vaccination form for Pfizer BioNtech Vaccine" document.

I am voluntarily receiving this vaccine. I understand the Pfizer-BioNTech COVID-19 Vaccine may not protect everyone.

I understand this vaccine requires 2 doses. I will receive one dose today and the second dose in 21 days. My appointment for the second vaccine was scheduled when I scheduled the appointment for today.

I understand that Pfizer-BioNTech COVID-19 Vaccine does not contain SARS-CoV-2 and cannot give me COVID-19.

I have reviewed the California Immunization Registry (CAIRs) information sheet and authorize my COVID 19 vaccination information to be shared with the registry.
Initial _____

I have had an opportunity to ask questions and have them answered by a Healthcare Professional.

By signing this form I am consenting to receive the Pfizer BioNtech COVID 19 vaccination.

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Patient Last Name: _____

Date: _____ Time: _____ AM / PM

Signature: _____
(patient)

Pfizer BioNtech COVID 19 information

Lot number: _____ **Expiration Date:** _____

Site of Administration (circle) **____R deltoid ____ L deltoid other:**
_____

Entered into CAIR: Date: _____ **Time** _____

Signature: _____

Staff use only - - - - - For Limited English Proficiency Patients only:

Interpreter name or ID# _____ ☐ Staff ☐ Phone ☐ Video
If you do not use an approved interpreter, please list the reason:
_____

Statement of Non-discrimination
Northern Inyo Healthcare District complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 760-873-5811 (TTY: 711).

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 760-873-5811
（TTY：7

Northern Inyo Healthcare District
One Team. One Goal. Your Health.
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Patient Last Name: _____

2nd Pfizer/BioNtech COVID 19 Vaccine Documentation-21 days later

Date Administered: _____

Lot number: _____ **Expiration Date:** _____

Site of Administration (circle) ____**R deltoid** ____ **L deltoid other:** _____

Entered into CAIR: Date: _____ **Time** _____

Signature of person giving vaccine: _____

The answers to the questions on my original vaccination consent have changed.

____ Yes _____ No

If yes, explain _____

I am voluntarily receiving the 2nd dose of this vaccine.

Patient Signature _____ Date _____