Pfizer-BioNTech

COVID-19 Vaccine FAQs

Can the vaccine give me COVID-19?

No. The Pfizer-BioNTech COVID-19 vaccine does not use the live virus that causes COVID-19. However, it typically takes a few weeks for the body to build immunity. That means it's possible you could be infected with the virus just before or just after vaccination.

What are the normal side effects from the COVID-19 vaccine?

Side effects may feel like flu and even affect your ability to do daily activities, but they should go away in a few days. The most common side effects include:

- Pain, redness, or swelling at the injection site
- Tiredness
- Headache
- Muscle pain
- Chills
- Joint pain
- Fever
- Nausea
- Swollen lymph nodes

How do I treat side effects from the COVID-19 vaccine?

If you have pain or discomfort, talk to your healthcare provider about taking an over-the-counter medicine, such as ibuprofen or acetaminophen.

Contact your healthcare provider if:

- Redness or tenderness where you got the shot increases after 24 hours
- Side effects are worrying you
- Side effects do not seem to be going away after a few days

Are there any serious side effects from the COVID-19 vaccine?

There may be unexpected side effects or a small chance of a severe allergic reaction, which would usually occur within a few minutes to one hour after getting a dose of the vaccine. If you experience a severe allergic reaction, call 9-1-1 or go to the nearest hospital. Signs of a severe allergic reaction can include:

- Difficulty breathing
- Swelling of your face and throat
- A fast heartbeat
- A bad rash all over your body
- Dizziness and weakness

Are there long-term side effects from the COVID-19 vaccine?

Because the vaccine is new, it will take more time to learn about very rare or possible long-term side effects. However, at least 8 weeks of safety data were gathered in the vaccine clinical trials, and it's unusual for vaccine side effects to appear more than 8 weeks after vaccination.

Am I protected from COVID-19 immediately after receiving the vaccine?

No. It takes time for your body to build protection. You may not be protected from COVID-19 until a week or two after your second shot.

When do I receive my second shot?

You will receive a vacation card that will show you when to return for your second dose. Please bring the card with you when you return.

If I get a COVID-19 vaccine, do I still need to take other precautions?

Yes, you should continue washing your hands, wearing a mask, staying six feet apart, and limiting gatherings. These precautions will help prevent the spread of COVID-19 to people who are not yet vaccinated.

Where can I get more information?

For more information about the COVID-19 vaccine, visit the following website:

- Centers for Disease Control and Prevention (www.cdc.gov/coronavirus/vaccine)
- Washington State Department of Health (www.doh.wa.gov/Emergencies/COVID19/Vaccine)
- Pfizer-BioNTech (www.cvdvaccine.com)

Preguntas frecuentes de la vacuna contra la COVID-19 de Pfizer-BioNTech

¿Puedo contraer COVID-19 al vacunarme?

No. La vacuna contra la COVID-19 de Pfizer-BioNTech no usa el virus vivo que causa COVID-19. Sin embargo, el cuerpo tarda regularmente unas semanas en desarrollar inmunidad. Eso significa que es posible que pueda infectarse con el virus justo antes o justo después de la vacunación.

¿Cuáles son los efectos secundarios normales de la vacuna contra la COVID-19?

Los efectos secundarios pueden sentirse como la gripe e incluso afectar su capacidad para realizar las actividades diarias, pero deberían desaparecer en unos días. Los efectos secundarios más comunes incluyen:

- Dolor, enrojecimiento o hinchazón en la zona de la inyección
- Cansancio
- Dolor de cabeza
- Dolor muscular
- Escalofríos
- Dolor de articulaciones
- Fiebre
- Náuseas
- Ganglios linfáticos inflamados

¿Cómo trato los efectos secundarios de la vacuna contra la COVID-19?

Si tiene dolor o malestar, hable con su proveedor de atención médica sobre la posibilidad de tomar un medicamento de venta libre, como ibuprofeno o acetaminofeno.

Comuníquese con su proveedor de atención médica si:

- El enrojecimiento o la sensibilidad en la zona donde recibió la inyección aumentan después de 24 horas.
- Los efectos secundarios le preocupan.
- Los efectos secundarios no parecen desaparecer después de unos días.

¿Hay algún efecto secundario grave de la vacuna contra la COVID-19?

Puede haber efectos secundarios inesperados y existe una pequeña posibilidad de tener una reacción alérgica grave, generalmente entre unos minutos a una hora después de recibir una dosis de la vacuna. Si experimenta una reacción alérgica grave, llame al 9-1-1 o acuda al hospital más cercano. Los signos de una reacción alérgica grave pueden incluir:

- Dificultad para respirar
- Hinchazón de rostro y garganta
- Ritmo cardíaco acelerado
- Erupción cutánea grave
- Mareos y debilidad

¿Hay algún efecto secundario a largo plazo de la vacuna contra la COVID-19?

Debido a que la vacuna es nueva, tomará más tiempo conocer los efectos secundarios a largo plazo posibles o poco frecuentes. Sin embargo, en los ensayos clínicos de la vacuna se recopilaron datos de seguridad en al menos 8 semanas, y es inusual que los efectos secundarios de una vacuna aparezcan más de 8 semanas después de la vacunación.

¿Estoy protegido contra la COVID-19 inmediatamente después de recibir la vacuna?

No. A su cuerpo le toma tiempo desarrollar protección. Es posible que no esté protegido contra la COVID-19 hasta una o dos semanas después de su segunda inyección.

¿Cuándo recibiré mi segunda inyección?

Recibirá una tarjeta de descanso que le mostrará cuándo debe regresar para su segunda dosis. Sírvase traer la tarjeta cuando regrese.

Si me vacuno contra la COVID-19, ¿debo tomar otras precauciones?

Sí, debe seguir lavándose las manos, usando una mascarilla, manteniéndose a seis pies de distancia y limitando las reuniones. Estas precauciones ayudarán a prevenir la propagación de la COVID-19 a personas que aún no están vacunadas.

¿Dónde puedo obtener más información?

Para obtener más información sobre la vacuna contra la COVID-19, visite los siguientes sitios web:

- Centros para el Control y la Prevención de Enfermedades (Centers for Disease Control and Prevention) (www.cdc.gov/coronavirus/vaccine)
- Departamento de Salud del Estado de Washington (Washington State Department of Health) (www.doh.wa.gov/Emergencies/COVID19/Vaccine)
- Pfizer-BioNTech (www.cvdvaccine.com)

FACT SHEET FOR RECIPIENTS AND CAREGIVERS

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

You are being offered the Pfizer-BioNTech COVID-19 Vaccine to prevent Coronavirus Disease 2019 (COVID-19) caused by SARS-CoV-2. This Fact Sheet contains information to help you understand the risks and benefits of the Pfizer-BioNTech COVID-19 Vaccine, which you may receive because there is currently a pandemic of COVID-19.

The Pfizer-BioNTech COVID-19 Vaccine is a vaccine and may prevent you from getting COVID-19. There is no U.S. Food and Drug Administration (FDA) approved vaccine to prevent COVID-19.

Read this Fact Sheet for information about the Pfizer-BioNTech COVID-19 Vaccine. Talk to the vaccination provider if you have questions. It is your choice to receive the Pfizer-BioNTech COVID-19 Vaccine.

The Pfizer-BioNTech COVID-19 Vaccine is administered as a 2-dose series, 3 weeks apart, into the muscle.

The Pfizer-BioNTech COVID-19 Vaccine may not protect everyone.

This Fact Sheet may have been updated. For the most recent Fact Sheet, please see www.cvdvaccine.com.

WHAT YOU NEED TO KNOW BEFORE YOU GET THIS VACCINE?

WHAT IS COVID-19?

COVID-19 disease is caused by a coronavirus called SARS-CoV-2. This type of coronavirus has not been seen before. You can get COVID-19 through contact with another person who has the virus. It is predominantly a respiratory illness that can affect other organs. People with COVID-19 have had a wide range of symptoms reported, ranging from mild symptoms to severe illness. Symptoms may appear 2 to 14 days after exposure to the virus. Symptoms may include: fever or chills; cough; shortness of breath; fatigue; muscle or body aches; headache; new loss of taste or smell; sore throat; congestion or runny nose; nausea or vomiting; diarrhea.

WHAT IS THE PFIZER-BIONTECH COVID-19 VACCINE?

The Pfizer-BioNTech COVID-19 Vaccine is an unapproved vaccine that may prevent COVID-19. There is no FDA-approved vaccine to prevent COVID-19.

The FDA has authorized the emergency use of the Pfizer-BioNTech COVID-19 Vaccine to prevent COVID-19 in individuals 16 years of age and older under an Emergency Use Authorization (EUA).

For more information on EUA, see the "**What is an Emergency Use Authorization (EUA)?**" section at the end of this Fact Sheet.

WHAT SHOULD YOU MENTION TO YOUR VACCINATION PROVIDER BEFORE YOU GET THE PFIZER-BIONTECH COVID-19 VACCINE?

Tell the vaccination provider about all of your medical conditions, including if you:

- have any allergies
- have a fever
- have a bleeding disorder or are on a blood thinner
- are immunocompromised or are on a medicine that affects your immune system
- are pregnant or plan to become pregnant
- are breastfeeding
- have received another COVID-19 vaccine

WHO SHOULD GET THE PFIZER-BIONTECH COVID-19 VACCINE?

FDA has authorized the emergency use of the Pfizer-BioNTech COVID-19 Vaccine in individuals 16 years of age and older.

WHO SHOULD <u>NOT</u> GET THE PFIZER-BIONTECH COVID-19 VACCINE?

You should not get the Pfizer-BioNTech COVID-19 Vaccine if you:

- had a severe allergic reaction after a previous dose of this vaccine
- had a severe allergic reaction to any ingredient of this vaccine

WHAT ARE THE INGREDIENTS IN THE PFIZER-BIONTECH COVID-19 VACCINE?

The Pfizer BioNTech COVID-19 Vaccine includes the following ingredients: mRNA, lipids ((4-hydroxybutyl)azanediyl)bis(hexane-6,1-diyl)bis(2-hexyldecanoate), 2 [(polyethylene glycol)-2000]-N,N-ditetradecylacetamide, 1,2-Distearoyl-sn-glycero-3-phosphocholine, and cholesterol), potassium chloride, monobasic potassium phosphate, sodium chloride, dibasic sodium phosphate dihydrate, and sucrose.

HOW IS THE PFIZER-BIONTECH COVID-19 VACCINE GIVEN?

The Pfizer-BioNTech COVID-19 Vaccine will be given to you as an injection into the muscle.

The Pfizer-BioNTech COVID-19 Vaccine vaccination series is 2 doses given 3 weeks apart.

If you receive one dose of the Pfizer-BioNTech COVID-19 Vaccine, you should receive a second dose of this same vaccine 3 weeks later to complete the vaccination series.

HAS THE PFIZER-BIONTECH COVID-19 VACCINE BEEN USED BEFORE?

The Pfizer-BioNTech COVID-19 Vaccine is an unapproved vaccine. In clinical trials, approximately 20,000 individuals 16 years of age and older have received at least 1 dose of the Pfizer-BioNTech COVID-19 Vaccine.

WHAT ARE THE BENEFITS OF THE PFIZER-BIONTECH COVID-19 VACCINE?

In an ongoing clinical trial, the Pfizer-BioNTech COVID-19 Vaccine has been shown to prevent COVID-19 following 2 doses given 3 weeks apart. The duration of protection against COVID-19 is currently unknown.

WHAT ARE THE RISKS OF THE PFIZER-BIONTECH COVID-19 VACCINE?

Side effects that have been reported with the Pfizer-BioNTech COVID-19 Vaccine include:

- injection site pain
- tiredness
- headache
- muscle pain
- chills
- joint pain
- fever
- injection site swelling
- injection site redness
- nausea
- feeling unwell
- swollen lymph nodes (lymphadenopathy)

There is a remote chance that the Pfizer-BioNTech COVID-19 Vaccine could cause a severe allergic reaction. A severe allergic reaction would usually occur within a few minutes to one hour after getting a dose of the Pfizer-BioNTech COVID-19 Vaccine. Signs of a severe allergic reaction can include:

- Difficulty breathing
- Swelling of your face and throat
- A fast heartbeat
- A bad rash all over your body
- Dizziness and weakness

These may not be all the possible side effects of the Pfizer-BioNTech COVID-19 Vaccine. Serious and unexpected side effects may occur. Pfizer-BioNTech COVID-19 Vaccine is still being studied in clinical trials.

WHAT SHOULD I DO ABOUT SIDE EFFECTS?

If you experience a severe allergic reaction, call 9-1-1, or go to the nearest hospital.

Call the vaccination provider or your healthcare provider if you have any side effects that bother you or do not go away.

Report vaccine side effects to **FDA/CDC Vaccine Adverse Event Reporting System (VAERS)**. The VAERS toll-free number is 1-800-822-7967 or report online to https://vaers.hhs.gov/reportevent.html. Please include "Pfizer-BioNTech COVID-19 Vaccine EUA" in the first line of box #18 of the report form.

In addition, you can report side effects to Pfizer Inc. at the contact information provided below.

Website	Fax number	Telephone number
www.pfizersafetyreporting.com	1-866-635-8337	1-800-438-1985

WHAT IF I DECIDE NOT TO GET THE PFIZER-BIONTECH COVID-19 VACCINE?
It is your choice to receive or not receive the Pfizer-BioNTech COVID-19 Vaccine. Should you decide not to receive it, it will not change your standard medical care.

ARE OTHER CHOICES AVAILABLE FOR PREVENTING COVID-19 BESIDES PFIZER-BIONTECH COVID-19 VACCINE?
Currently, there is no approved alternative vaccine available for prevention of COVID-19. FDA may allow the emergency use of other vaccines to prevent COVID-19.

CAN I RECEIVE THE PFIZER-BIONTECH COVID-19 VACCINE WITH OTHER VACCINES?
There is no information on the use of the Pfizer-BioNTech COVID-19 Vaccine with other vaccines.

WHAT IF I AM PREGNANT OR BREASTFEEDING?
If you are pregnant or breastfeeding, discuss your options with your healthcare provider.

WILL THE PFIZER-BIONTECH COVID-19 VACCINE GIVE ME COVID-19?
No. The Pfizer-BioNTech COVID-19 Vaccine does not contain SARS-CoV-2 and cannot give you COVID-19.

KEEP YOUR VACCINATION CARD
When you get your first dose, you will get a vaccination card to show you when to return for your second dose of Pfizer-BioNTech COVID-19 Vaccine. Remember to bring your card when you return.

ADDITIONAL INFORMATION
If you have questions, visit the website or call the telephone number provided below.

To access the most recent Fact Sheets, please scan the QR code provided below.

Global website	Telephone number
www.cvdvaccine.com	1-877-829-2619 (1-877-VAX-CO19)

HOW CAN I LEARN MORE?
- Ask the vaccination provider.
- Visit CDC at https://www.cdc.gov/coronavirus/2019-ncov/index.html.
- Visit FDA at https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization.
- Contact your local or state public health department.

WHERE WILL MY VACCINATION INFORMATION BE RECORDED?
The vaccination provider may include your vaccination information in your state/local jurisdiction's Immunization Information System (IIS) or other designated system. This will ensure that you receive the same vaccine when you return for the second dose. For more information about IISs visit: https://www.cdc.gov/vaccines/programs/iis/about.html.

WHAT IS THE COUNTERMEASURES INJURY COMPENSATION PROGRAM?
The Countermeasures Injury Compensation Program (CICP) is a federal program that may help pay for costs of medical care and other specific expenses of certain people who have been seriously injured by certain medicines or vaccines, including this vaccine. Generally, a claim must be submitted to the CICP within one (1) year from the date of receiving the vaccine. To learn more about this program, visit www.hrsa.gov/cicp/ or call 1-855-266-2427.

WHAT IS AN EMERGENCY USE AUTHORIZATION (EUA)?
The United States FDA has made the Pfizer-BioNTech COVID-19 Vaccine available under an emergency access mechanism called an EUA. The EUA is supported by a Secretary of Health and Human Services (HHS) declaration that circumstances exist to justify the emergency use of drugs and biological products during the COVID-19 pandemic.

The Pfizer-BioNTech COVID-19 Vaccine has not undergone the same type of review as an FDA-approved or cleared product. FDA may issue an EUA when certain criteria are met, which includes that there are no adequate, approved, available alternatives. In addition, the FDA decision is based on the totality of scientific evidence available showing that the product may be effective to prevent COVID-19 during the COVID-19

pandemic and that the known and potential benefits of the product outweigh the known and potential risks of the product. All of these criteria must be met to allow for the product to be used in the treatment of patients during the COVID-19 pandemic.

The EUA for the Pfizer-BioNTech COVID-19 Vaccine is in effect for the duration of the COVID-19 EUA declaration justifying emergency use of these products, unless terminated or revoked (after which the products may no longer be used).

Manufactured by
Pfizer Inc., New York, NY 10017

Manufactured for
BioNTech Manufacturing GmbH
An der Goldgrube 12
55131 Mainz, Germany

LAB-1451-0.7

Revised: December 2020

Scan to capture that this Fact Sheet was provided to vaccine recipient for the electronic medical records/immunization information systems.

Barcode Date: 12/2020

Samaritan Healthcare | 801 E. Wheeler Road, Moses Lake, WA 98837 | Grant County

Pfizer-BioNTech COVID-19 Vaccine Patient Acknowledgment

Patient Name (Last, First): _____ DOB: ____/____/_____

Phone: _____ Mobile Phone: _____Email: _____
(This information will be used to contact you for your second dose reminder.)

Address: _____ City, State, Zip Code: _____

Healthcare Provider's Place of Business: _____

Information collected in this section helps ensure we deliver equitable and patient-centered care:
Sex listed at birth (check one):

Male: ☐	Female: ☐

Gender identity (check one):

Male: ☐	Female: ☐	Non-Binary ☐	Unspecified/Indeterminant: ☐

Ethnicity (Check one):

Hispanic or Latino (Including Spanish, Mexican, Puerto Rican, Cuban, etc. ☐	Not-Hispanic A person not of Spanish culture or origin ☐

Race: (Check all that apply):

Black or African American ☐ White ☐	Asian ☐ American Indian or Alaska Native ☐	Hawaiian or Pacific Islander ☐

Vaccine Dose (check one): 1st ☐ 2nd ☐ If this is your second dose, what vaccine was your first? Pfizer ☐ Moderna ☐ Don't know ☐ If this is your second dose, when did you receive your first dose? (date): _____.

Exclusion Questions: Answering yes to either of these questions excludes you from receiving the vaccine.

Do you have a known history of a severe allergic reaction (e.g. anaphylaxis) to this vaccine or any components of the vaccine such as lipids, potassium chloride, monobasic potassium phosphate, sodium chloride, dibasic sodium phosphate dihydrate, and sucrose? (Full list is available in the *Fact Sheet for Vaccine Recipients and Caregivers* or from your health care provider.)	Yes	No
Are you under the age of 16 years?	Yes	No

Screening Questions: *Immunizer: If patient answers "yes" to any of the below, provide patient counseling or instruct them to consult with their caregiver prior to receiving the vaccine.*

In the past two weeks have you tested positive for COVID-19?	Yes	No
In the past two weeks have you had exposure to a person who tested positive for COVID-19 at a distance of six feet or less for a period of 15 or more minutes without wearing appropriate personal protective equipment?	Yes	No
Have you had a new onset of fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting or diarrhea?	Yes	No
In the past 90 days have you received passive antibody therapy as part of COVID-19 treatment?	Yes	No
Are you pregnant or breastfeeding or do you plan to become pregnant?	Yes	No
Are you immune compromised or on a medicine that affects your immune system?	Yes	No
Do you have a bleeding disorder or are you on a blood thinner?	Yes	No
Do you have a history of severe allergic reaction (e.g. anaphylaxis) to another vaccine or injectable medication? If yes, what vaccine or injectable medication: _____	Yes	No

Insurance Information:

Insurance company: _____ Are you the primary card holder? Y N

If no, what is the primary card holders name and date of birth? _____

Cardholder ID: _____ Rx Group ID: _____

BIN: _____ PCN: _____

Are you Medicare eligible? Y N If yes, Medicare Part A/B number: _____

If you are not insured and you do not want to pay for administration of the vaccine yourself, you must provide the information below. If you do not provide this information you may be billed for vaccine administration.

I do not have any insurance, including but not limited to Medicare, Medicaid, or any other private or government-funded health benefit plan. In order to have your vaccine administration fee paid for by the United States Health Resources & Services Administration's COVID-19 Program for Uninsured Patients please provide (a) a valid Social Security number, or (b) state identification number and state of issuance, or (c) a driver's license number and the state of issuance: _____

Acknowledgements:

I made the choice to get the COVID-19 vaccine on my own and freely. I know I have the option to refuse the vaccine. I ask that the vaccine be given to me, or to the person named above for whom I can make this request. I was given the (Fact Sheet for Vaccine Recipients and Caregivers) for this vaccine. The fact sheet *has information about side effects and adverse reactions. I read or had read to me the information provided about the COVID-19 vaccine.*

I know the Food and Drug Administration (FDA) has authorized the emergency use of this vaccine. I know it is not a fully licensed FDA vaccine. I had the chance to ask questions that were answered to my satisfaction. I now know about the vaccine, alternatives, benefits, and risks, to the extent they are known and unknown at this time.

I know that I must stay in the vaccine area or an area told to me by my health care provider after I receive my immunization so I am near my health care provider if I have any adverse reactions.. If I have a history of severe allergic reaction, (e.g. anaphylaxis), I must stay for 30 minutes. If I do not have a history of severe allergic reaction, I must stay for 15 minutes

I know that if I have a severe allergic reaction, including difficulty breathing, swelling of my face and/or throat, a fast heartbeat, a bad rash all over my body or dizziness and weakness I should call 9-1-1 or go to the nearest hospital. I know I can call my health care provider if I have any side effects that bother me or do not go away.

I was asked to join the V-SAFE program. The program does health checks on the people who get the COVID-19 vaccine. I know I should report vaccine side effects to FDA/CDC Vaccine Adverse Event Reporting System (VAERS) at 1-800-822-7967 or https://vaers.hhs.gov/reportevent.html.

I know I must get two doses of the COVID-19 vaccine and receive the same vaccine each time. I know that with all vaccines there is no promise I will become immune (not get the virus) or that I will not have side effects. I know I may choose to not get the second dose of the vaccine. But if I do not get the second dose, the chance that I will become immune may go down.

Authorization to Request Payment: *I authorize the organization providing my vaccine to release information and request payment. I certify that the information given by me in applying for payment under Medicare or Medicaid or the HRSA COVID-19 Program for Uninsured Patients, is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.*

Disclosure of Records: *I understand the organization providing my vaccine may be required to or may voluntarily disclose my vaccine-related health information to my primary care physician, my insurance plan, health systems and hospitals, and state or federal registries or other public health authorities, for purposes of treatment, payment or health care operations. I also understand the organization providing my vaccine will use and disclose my health information as described in its Notice of Privacy Practices which I may receive upon request or find on its website. If I am an employee of Samaritan Healthcare. I understand that it will keep records of this vaccination for me in EPIC and may keep my vaccination records in [insert name of health care provider]'s employee occupational health records, to the extent required or permitted by law.*

Patient (or Parent/Guardian/Authorized Representative) Signature: _____ Date: _____

Name of Parent, Guardian or Authorized Representative: _____ Date: _____

If you are signing on behalf of the patient, you are stating that you are authorized to make the required decisions on behalf of the patient.

All sections below are for official use only:

Vaccine Administration Information for Immunizer:

Administration date: _____ Administration time: _____

CVX (Product): _____

Dose number: _____

IIS Recipient ID: _____

IIS vaccination event ID: _____

Lot number: _____

Unit of Use MVX (Manufacturer): _____

Sending organization: _____

Vaccine administering provider suffix: _____

Vaccine administering site on the body: Left deltoid ☐ Right deltoid ☐ Other ☐ (indicate location) _____

Vaccine expiration date: _____

Vaccine route of administration: _____

Vaccination series complete (date): _____

Fact Sheet for Vaccine Recipients and Caregivers version date: _____

Notes about this form:

This form should only be provided to a patient if it is accompanied by the Fact Sheet for Vaccine Recipients and Caregivers https://www.cvdvaccine.com/***.***

This form should only be used by clinicians well versed in the CDC's provider education materials who are able to counsel patients who answer "yes" to the screening questions or make referrals for counseling for those patients.

This form is intended as a resource. It is not a mandatory form.

This form was developed based on the best available information at the time it was created. Its accuracy is not guaranteed. Organizations and individuals choosing to use this form should do so in consultation with their own clinicians and attorneys.

This form is subject to update without notice.

For convenience, some elements in this form may be pre-recorded in electronic health records or other databases.

Resources used in creating this form:

- COVID-19 Vaccination Training Programs and Reference Materials for Healthcare Professionals for information about screening questions and *Fact Sheet for Vaccine Recipients and Caregivers* https://www.cdc.gov/vaccines/covid-19/downloads/COVID-19-Clinical-Training-and-Resources-for-HCPs.pdf
- Global Information About Pfizer-BioNTech COVID-19 Vaccine (also known as BNT162b2): https://www.cvdvaccine.com/
- V-Safe Program; https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/vsafe.html
- COVID-19 Vaccination Communication Toolkit: https://www.cdc.gov/vaccines/covid-19/health-systems-communication-toolkit.html
- Washington State's COVID-19 Vaccine Plan for vaccine reporting requirements. https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/WA-COVID-19-Vaccination-Plan.pdf
- For Demographic Information:
  - Washington State CHARS Manual: https://www.doh.wa.gov/Portals/1/Documents/5300/CHARSManual-UB04-5010.pdf
  - Race Ethnicity Language Data Collection Best Practices: http://forces4quality.org/af4q/download-document/6011/Resource-validated_final_rel_data_collection_best_practice_guidelines_updated_11-28.pdf
  - Collecting Sexual Orientation and Gender Identity Information: https://www.cdc.gov/hiv/clinicians/transforming-health/health-care-providers/collecting-sexual-orientation.html

Acuse de recibo del paciente de la vacuna Pfizer-BioNTech contra la COVID-19

Nombre del paciente (apellido, nombre): _____ Fecha de nacimiento: ____/____/_____

Teléfono: _____ Teléfono móvil: _____Correo electrónico: _____
(Se utilizará esta información para comunicarnos con usted para recordarle su segunda dosis).

Dirección: _____ Ciudad, estado, código postal: _____

Centro del proveedor de atención médica: _____

La información recopilada en esta sección ayuda a garantizar que brindemos una atención equitativa y enfocada en el paciente:
Sexo indicado al nacer (marque uno):

Masculino: ☐	Femenino: ☐

Identidad de género (marque una):

Masculino: ☐	Femenino: ☐	No binario ☐	No especificado/indeterminado: ☐

Identidad étnica (marque una):

Hispano o latino (por ejemplo, español, mexicano, puertorriqueño, cubano, etc.) ☐	No hispano (una persona que no es de cultura u origen español) ☐

Raza: (Marque todas las que corresponden):

Negro o afroamericano ☐ Blanco ☐	Asiático ☐ Indio americano o nativo de Alaska ☐	Hawaiano o isleño del Pacífico ☐

Dosis de la vacuna (marque una): 1.ª ☐ 2.ª ☐ Si esta es su segunda dosis, ¿qué vacuna fue la primera? Pfizer ☐ Moderna ☐ No lo sé ☐ Si esta es su segunda dosis, ¿cuándo recibió la primera dosis? (fecha): _____.

Preguntas de exclusión: Responder afirmativamente a alguna de estas preguntas lo excluye de recibir la vacuna.

¿Sabe si tiene antecedentes de una reacción alérgica grave (p. ej., anafilaxia) a esta vacuna o a algún componente de la vacuna como lípidos, cloruro de potasio, fosfato de potasio monobásico, cloruro de sodio, fosfato de sodio dibásico dihidrato y sacarosa? (La lista completa está disponible en la *hoja informativa para receptores de la vacuna y cuidadores* o de su proveedor de atención médica).	Sí	No
¿Tiene menos de 16 años?	Sí	No

Preguntas de selección: *Inmunizador: Si el paciente responde "sí" a cualquiera de las siguientes preguntas, brinde asesoramiento al paciente o indíquele que consulte con su cuidador antes de recibir la vacuna.*

En las últimas dos semanas, ¿dio positivo en la prueba de COVID-19?	Sí	No
En las últimas dos semanas, ¿ha estado expuesto a una persona que dio positivo en la prueba de COVID-19 a una distancia de seis pies o menos durante un período de 15 o más minutos sin usar el equipo de protección personal de forma correcta?	Sí	No
¿Ha tenido un nuevo episodio de fiebre, escalofríos, tos, falta de aire, dificultad para respirar, fatiga, dolores musculares o corporales, dolor de cabeza, nueva pérdida del gusto u olfato, dolor de garganta, náuseas, vómitos o diarrea?	Sí	No
En los últimos 90 días, ¿ha recibido terapia pasiva con anticuerpos como parte del tratamiento de COVID-19?	Sí	No
¿Está embarazada o dando de lactar o planea quedar embarazada?	Sí	No
¿Está inmunodeprimido o tomando un medicamento que afecta su sistema inmune?	Sí	No
¿Tiene algún trastorno hemorrágico o toma anticoagulantes?	Sí	No
¿Tiene antecedentes de reacción alérgica grave (p. ej., anafilaxia) a otra vacuna o medicamento inyectable? Si es así, qué vacuna o medicamento inyectable: _____	Sí	No

Información del seguro:

Compañía de seguros: _____ ¿Es el titular de la tarjeta principal? S N

Si no es así, ¿cuál es el nombre del titular de la tarjeta principal y la fecha de nacimiento? _____

Identificación del titular de la tarjeta: _____ Identificación del grupo Rx: _____

BIN: _____ PCN: _____

¿Es usted apto para recibir Medicare? S N Si es así, indique el número de la Parte A/B de Medicare: _____

Si no está asegurado y no desea pagar usted mismo la administración de la vacuna, debe proporcionar la siguiente información. Si no proporciona esta información, se le puede facturar por la administración de la vacuna.

No tengo ningún seguro, incluyendo, entre otros, Medicare, Medicaid o cualquier otro plan de beneficios de salud privado o financiado por el gobierno. Para que el programa COVID-19 de la Administración de Recursos y Servicios de Salud de los Estados Unidos pague la tarifa de administración de la vacuna para pacientes sin seguro, proporcione (a) un número de seguro social válido o (b) el número de identificación del estado y el estado de emisión o (c) un número de licencia de conducir y el estado de emisión: _____

Acuses de recibo:

Decidí recibir la vacuna de COVID-19 por mi cuenta y voluntariamente. Sé que tengo la opción de rechazar la vacuna. Pido que se me administre la vacuna a mí o a la persona mencionada anteriormente por quien puedo hacer esta solicitud. Recibí la (hoja informativa para receptores de la vacuna y cuidadores) para esta vacuna. La hoja informativa *tiene información sobre los efectos secundarios y las reacciones adversas. Leí o me leyeron la información proporcionada sobre la vacuna de COVID-19.*

Sé que la Administración de Alimentos y Medicamentos (FDA, por sus siglas en inglés) ha autorizado el uso de la vacuna en casos de emergencia. Sé que no es una vacuna completamente autorizada por la FDA. Tuve la posibilidad de hacer preguntas que fueron respondidas satisfactoriamente. Ahora sé sobre la vacuna, las alternativas, los beneficios y los riesgos en la medida en que se conocen y se desconocen en este momento.

Sé que debo quedarme en el área de vacuna o en un área que mi proveedor de atención médica indique después de recibir mi vacuna para así estar cerca de mi proveedor de atención médica si tengo alguna reacción adversa. Si tengo un antecedente de reacción alérgica grave (p. ej., anafilaxia), debo quedarme por 30 minutos. Si no tengo un antecedente de reacción alérgica grave, debo quedarme por 15 minutos.

Sé que si tengo una reacción alérgica grave, entre ellos, dificultad para respirar, hinchazón en mi cara o garganta, ritmo cardíaco rápido, urticaria en todo el cuerpo o mareos y debilidad, debo llamar al 9-1-1 o ir al hospital más cercano. Sé que puedo llamar a mi proveedor de atención médica si tengo algún efecto secundario que me molesta o no se va.

Se me pidió unirme al programa V-SAFE. El programa hace controles de salud a las personas que reciben la vacuna contra la COVID-19. Sé que debo informar los efectos secundarios de la vacuna a la FDA/CDC, Sistema para Reportar Reacciones Adversas a las Vacunas (VAERS, por sus siglas en inglés) al 1-800-822-7967 o https://vaers.hhs.gov/reportevent.html.

Sé que debo recibir dos dosis de la vacuna contra la COVID-19 y recibir la misma vacuna cada vez. Sé que no hay certeza de que al recibir todas las vacunas me volveré inmune (no contraer el virus) o que no tendré efectos secundarios. Sé que puedo decidir no recibir la segunda dosis de la vacuna. Sin embargo, si no recibo la segunda dosis, la probabilidad de que me vuelva inmune puede disminuir.

Autorización para solicitar el pago: *Autorizo a la organización que proporciona mi vacuna para que divulgue información y solicite el pago. Certifico que la información que proporcioné al solicitar el pago de Medicare o Medicaid o del Programa de HRSA de COVID-19 para pacientes sin seguro es correcta. Autorizo la divulgación de todos los registros para proceder con esta solicitud. Solicito que el pago de los beneficios autorizados se realice en mi nombre.*

Divulgación de registros: *entiendo que la organización que proporciona mi vacuna puede estar obligada o puede divulgar voluntariamente mi información médica relacionada con la vacuna a mi médico de atención primaria, mi plan de seguro, sistemas de salud y hospitales, y registros estatales o federales u otras autoridades de salud pública, para fines de tratamiento, pago u operaciones de atención médica. También entiendo que la organización que proporciona mi vacuna utilizará y divulgará mi información de salud tal como se indica en su Aviso de prácticas de privacidad que puedo recibir con previa solicitud o encontrar en su sitio web. Si soy empleado de Samaritan Healthcare entiendo que mantendré los registros de esta vacuna para mí en EPIC y puedo mantener los registros de mi vacuna en los registros de salud ocupacional del empleado de [insert name of health care provider] en la medida que la ley lo requiera o permita.*

Firma del paciente (o padre/madre/tutor/representante autorizado): _____ Fecha: _____

Nombre del padre, la madre, el tutor o el representante autorizado: _____ Fecha: _____

Si firma en nombre del paciente, confirma que está autorizado para tomar las decisiones necesarias en nombre del paciente.

Todas las siguientes secciones son solo para uso oficial:

Información sobre la administración de vacunas para la inmunización:

Fecha de la administración: _____ Hora de la administración: _____

CVX (Producto): _____

Cantidad de dosis: _____

Identificación del receptor del IIS: _____

Identificación del evento de vacunación del IIS: _____

Número de lote: _____

Unidad de uso MVX (fabricante): _____

Organización de envío: _____

Sufijo del proveedor que administra la vacuna: _____

Lugar de administración de la vacuna en el cuerpo: Deltoide izquierdo ☐ Deltoide derecho ☐ Otro ☐ (indique la ubicación) _____

Fecha de caducidad de la vacuna: _____

Ruta de administración de la vacuna: _____

Serie de vacunación completa (fecha): _____

Fecha de la versión de la hoja informativa para los receptores de la vacuna y cuidadores: _____

Notas sobre este formulario:

Este formulario solo debe proporcionarse a un paciente si va acompañado de la hoja informativa para receptores de la vacuna y cuidadores https://www.cvdvaccine.com/***.***

Solo los médicos clínicos expertos en los materiales educativos para proveedores de los CDC deben utilizar este formulario ya que pueden asesorar a los pacientes que respondan "sí" a las preguntas de selección o hacer referencias para el asesoramiento a esos pacientes.

Este formulario está diseñado para ser un recurso. No es un formulario obligatorio.

Este formulario se elaboró en base a la mejor información disponible en el momento de su creación. No se garantiza su precisión. Las organizaciones y las personas que eligen usar este formulario deben hacerlo consultando con sus propios médicos y abogados.

Este formulario está sujeto a actualizaciones sin previo aviso.

Para mayor facilidad, algunos elementos en este formulario pueden estar pregrabados en registros médicos electrónicos u otras bases de datos.

Recursos utilizados en la elaboración de este formulario:

- Programas de capacitación de vacunas de COVID-19 y materiales de referencia para profesionales de atención médica para obtener información sobre las preguntas de selección y *hoja informativa para receptores de la vacuna y cuidadores* https://www.cdc.gov/vaccines/covid-19/downloads/COVID-19-Clinical-Training-and-Resources-for-HCPs.pdf
- Información global sobre la vacuna Pfizer-BioNTech contra la COVID-19 (también conocido como BNT162b2): https://www.cvdvaccine.com/
- Programa V-Safe; https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/vsafe.html
- Instructivo de comunicación sobre la vacuna contra la COVID-19: https://www.cdc.gov/vaccines/covid-19/health-systems-communication-toolkit.html
- Plan de vacunación contra la COVID-19 del estado de Washington para los requisitos de información de la vacuna. https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/WA-COVID-19-Vaccination-Plan.pdf
- Para información demográfica:
  - Manual de CHARS del estado de Washington: https://www.doh.wa.gov/Portals/1/Documents/5300/CHARSManual-UB04-5010.pdf
  - Buenas prácticas de recopilación de datos sobre raza, identidad étnica, idioma: http://forces4quality.org/af4q/download-document/6011/Resource-validated_final_rel_data_collection_best_practice_guidelines_updated_11-28.pdf
  - Recopilación de información sobre orientación sexual e identidad de género: https://www.cdc.gov/hiv/clinicians/transforming-health/health-care-providers/collecting-sexual-orientation.html