Clinical Use			
Temperature: ___________________			
Vaccine Site: ◻ Right Arm		◻ Left Arm	
◻ Dose 1	◻ Dose 2	◻ Dose 3	◻ Booster Dose

Pfizer COVID-19 Vaccination Consent Form

Patient Name (print clearly): ____ **Date**:______________________

Birth Date:______________________

The Pfizer COVID-19 Vaccine has been fully approved by the Federal Drug Administration (FDA) as Comirnaty® for use in individuals **16 years of age and older**. The Pfizer COVID-19 Vaccine has been authorized by the FDA under an Emergency Use Authorization (EUA) for individuals **5 years of age and older**, for administration of a third dose for immunocompromised people and for a single booster dose for select individuals.
A copy of the EUA is available upon request or by visiting our website.

Pfizer Vaccine side effects that have been reported in clinical trials include, but are not limited to: injection site pain • tiredness • headache • muscle pain • chills • joint pain • fever • injection site swelling • injection site redness • nausea • feeling unwell • swollen lymph nodes (lymphadenopathy). These symptoms are not severe in the majority of cases, and usually resolve within 24 hours. Certain severe allergic reactions have been reported outside of clinical trials; if you develop symptoms of an allergic reaction following vaccination (such as trouble breathing, chest pain or a fast heartbeat, dizziness, weakness, swelling of the face, throat, or tongue, or a rash all over your body), call 911 or go to the nearest Hospital Emergency Department.

QUESTIONS	YES	NO
1.Are you ill today? (fever, cold symptoms etc.)?		
2.Have you been diagnosed with COVID-19 with a PCR test in the past 10 days?		
3.Have you ever had an allergic reaction to the components of the Pfizer COVID-19 Vaccine?		
4.Have you received passive antibody treatment for COVID-19 in the past 90 days?		
5.Have you ever had an anaphylactic reaction(e.g. trouble breathing, broke out in hives, had facial or tongue swelling, had low blood pressure), or had other severe symptoms after receiving another vaccination or an injectable medication (a shot given intravenously, intramuscularly, or subcutaneously)?		
6.Do you have a history of an anaphylactic reaction to anything other than a vaccine or injectable medication (food, insect sting, oral medication)?		
7.Do you have a bleeding disorder or take a blood thinner?		

QUESTIONS BELOW ARE FOR THOSE WHO WERE PREVIOSLY FULLY VACCINATED FOR COVID

Please select EITHER A or B below to

A. Are you **immunocompromised** and has it been at least 28 days since your last COVID vaccination?		
B. Are you seeking a **Pfizer booster** , 18 years of age or older, and has it been at least 6 months since your last COVID vaccination? (at least 2 months for Janssen J&J)		

If you answered "Yes" to any of the questions 1 to 4, you should not have the Pfizer Vaccine today:

- If you are sick, we recommend you delay vaccination until your symptoms have resolved. If you are diagnosed with COVID-19 you should delay the vaccination for 10 days after diagnosis.
- If you have a history of anaphylaxis to any of the ingredients in the Pfizer Vaccine, you should not receive the Pfizer Vaccine at any time, based on current guidance.
- If you have received passive antibody treatment for COVID-19, it is recommended to wait 90 days after treatment before receiving the Pfizer Vaccine

If you answered "Yes" to question 5, 6, or 7, notify the staff before receiving the Pfizer Vaccine. If you have a history of anaphylaxis to something other than the Pfizer Vaccine ingredients, we will increase your monitoring time after vaccination to make sure there is no evidence of an anaphylactic reaction. If you have a history of a bleeding disorder or take a blood thinner, we will monitor for bleeding at the injection site.

If you are ready to receive the Pfizer Vaccine, please read the statement below and sign your name to indicate your consent.

CONSENT FOR PFIZER VACCINE – Complete if requesting vaccination.

☐ I verify that I have been provided with and have read (or had read to me) (1) the Emergency Use Authorization Fact Sheet for the COVID-19 Pfizer Vaccine if applicable; (2) this COVID-19 Vaccine Consent Form for the Pfizer Vaccine; and (3) any additional information provided to me concerning COVID-19 vaccination. I acknowledge that I have had a chance to ask questions of a medical professional about the Pfizer Vaccine. I understand that the Pfizer Vaccine will be given in two separate doses, three weeks (21 days) apart. I understand that the CDC recommends some individuals receive a **booster dose at least 6 months** after completing the initial series. I understand that the CDC recommends that people whose immune systems are compromised moderately to severely should receive an additional **3rd dose** of Pfizer after the initial 2 doses **at least 28 days** after completing the initial series. I understand the known risks and the potential benefits of receiving the Pfizer Vaccine, and I understand there may be risks to the Pfizer Vaccine that are not known at this time. I understand that the FDA has authorized use of the Pfizer Vaccine under an Emergency Use Authorization (EUA) and that there is currently not enough scientific evidence available for the FDA to fully approve this COVID-19 vaccine in certain circumstances. I nonetheless request and consent to the Pfizer Vaccine being given to me or my dependent.

I understand it is recommended that I remain on site for at least 15 minutes after receiving the Pfizer Vaccine and that, depending on the recommendations of medical professionals, I may be asked to remain on site longer for monitoring.

Patient signature: ______________________________ **Date: _________________**

If patient is under 18 years of age or impaired,

Parent/guardian signature: ______________________________

Vaccine Administered by: _____________________________________

Time administered__________________

Time departed______________________

Lot Number