

Pfizer-BioNTech COVID-19 Vaccine CONSENT 2021

Hospital/Clinic Location: Grand Itasca Clinic & Hospital

Last Name (Print Legibly) _____ Legal First Name _____

Date of Birth _____ Age on date of vaccination* _____

****Note:** If patient is under the age of 18 on date of vaccination, must have guardian's written consent

*** NOTE:** Individual must be 5+ years of age on date of Pfizer-BioNTech COVID-19 Vaccine

1. Are you 5 years of age or older, if receiving the initial series, or 18 years of age or older if receiving a booster?
Yes No
2. Which dose in this series are you receiving? **First Second Third (Immunocompromised) Booster**
3. If receiving a second dose, has it been more than 17 days since your first dose? Or, if receiving the immunocompromised third dose, has it been more than 28 days since receiving the second Pfizer vaccine? Or, if receiving the booster dose, has it been more than 6 months since receiving the second Pfizer vaccine? **Yes No**
4. Have you had a previous severe allergic reaction (anaphylaxis) after any vaccine or shot? **Yes No**
5. Have you ever been told you have an allergy to polysorbate, polyethyleneglycol (PEG) or any ingredient of the COVID-19 vaccine? **Yes No**
6. Have you been *diagnosed* with a COVID-19 infection in the last 14 days and are still in quarantine? **Yes No**
7. Have you received antibodies or plasma to treat COVID-19 in the past 90 days? **Yes No**
8. Have you been in *contact* with someone diagnosed with COVID-19 in the last 14 days and are still in quarantine?
Yes No
9. Are you feeling sick today? **Yes No**
10. Have you had COVID with MISA (Multisystem Inflammatory Syndrome in Adults) or MISC (Multisystem Inflammatory Syndrome in Children) in the past 90 days? **Yes No**

ACKNOWLEDGMENT: I have been offered, read or have had explained to me the Pfizer-BioNTech COVID-19 Vaccine Fact Sheet about COVID-19 and the COVID-19 vaccine. I have had a chance to ask questions which were answered to my satisfaction. My election below is based upon my belief that I understand the benefits and risks of the Pfizer-BioNTech COVID-19 vaccine. **Initial here:** _____

Signature of person receiving vaccine or Signature of guardian and relationship (if person receiving vaccine is <18 years of age):

X _____ Date of Consent: _____

Vaccine:	Manufacturer:	Lot #:	Expiration Date:
<input type="checkbox"/> Pfizer-BioNTech COVID-19 Vaccine (age 12+) 0.3 ml <input type="checkbox"/> Pfizer-BioNTech COVID-19 Vaccine (age 5-11) 0.2 ml	Pfizer-BioNTech		
Check site: <input type="checkbox"/> Left Deltoid <input type="checkbox"/> Right Deltoid	Pfizer-BioNTech COVID-19 Vaccine Fact Sheet		Route: IM Refer to PMD for alternate site requests
Date Vaccine Given:	Pfizer-BioNTech COVID-19 Immunization Administered by (legible signature, first & last name):		(Circle) RN LPN CMA RPh
	Employee Vaccinator ID Number:		MD PA