COVID-19 VACCINE CONSENT FORM

MEDICAL HISTORY: Complete the following questions for the individual receiving the vaccine. If you answer "YES" you may not be able to receive the COVID-19 vaccine.

**If YES and further guidance is needed, Refer to Pfizer website at www.PfizerMedInfo.com or call 1-800-438-1985 for vaccine information on efficacy, safety, stability, dosage, vaccine ingredients, mechanism of action and administration.*

**If YES, some individuals may still receive the COVID-19 vaccine unless otherwise contraindicated.*

☐ Yes	☐ No	Are you less than 16 years old?
☐ Yes	☐ No	Have you ever had severe allergic reaction (anaphylactic reaction) to any vaccine, vaccine component or injectable therapy? Such as difficulty breathing, swelling of your face and throat, fast heartbeat, bad rash all over your body, dizziness and weakness.
☐ Yes	☐ No	Have you had a seizure or a brain or other nervous system problem or Gullian-Barré Syndrome?
☐ Yes	☐ No	Are you pregnant, breastfeeding or planning to become pregnant? Women in this group may receive COVID-19 vaccine, a discussion with your healthcare provider can help make informed decision.
☐ Yes	☐ No	Are you immunocompromised, take inmmunocompromising medications (e.g. prednisone, cortisone, other steroids, anticancer medications, or radiation treatments),or have HIV/AIDS, rheumatoid arthritis, cancer, leukemia, sickle cell, ankylosing spondylitis, Crohn's disease or any other immune system problem?
☐ Yes	☐ No	Do you have any chronic health conditions such as diabetes, chronic kidney disease, lung disease, heart disease, liver disease, asthma, severe obesity, etc.? These individuals may still receive COVID-19 vaccine unless otherwise contraindicated.
☐ Yes	☐ No	Have you had a previous COVID-19 vaccine? If yes, document date. _____
☐ Yes	☐ No	Have you had any vaccines within the previous 14 days? Pfizer-BioNTech COVID-19 vaccine should be administered alone with minimal interval of 14 days before or after any other vaccine.
☐ Yes	☐ No	Have you been diagnosed with COVID-19 within the last 90 days?
☐ Yes	☐ No	Have you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? Vaccination should be deferred for at least 90 days from treatment date to avoid interference of treatment with vaccine-induced immune responses.
☐ Yes	☐ No	Have you knowingly had unprotected exposure to someone who is positive for COVID-19 in the past 14 days?
☐ Yes	☐ No	Have you been tested for COVID-19 and still awaiting test results?

I currently have the following symptoms of COVID-19 (answer "Yes" or "No" to each symptom)

☐ Yes	☐ No	Fever or chills	☐ Yes	☐ No	New loss of taste or smell
☐ Yes	☐ No	Cough	☐ Yes	☐ No	Congestion or runny nose
☐ Yes	☐ No	Shortness of breath or difficulty breathing	☐ Yes	☐ No	Nausea or vomiting
☐ Yes	☐ No	Fatigue	☐ Yes	☐ No	Diarrhea
☐ Yes	☐ No	Muscle or body aches	☐ Yes	☐ No	Headache
☐ Yes	☐ No	Sore throat			

VACCINE ADMINISTRATION:

Is this the patient's first or second dose of the COVID-19 vaccination? ☐ First ☐ Second

Provider/Clinician Name Who Approved Ezinne Nwude, MD				Date/Time
Injection Site ☐ Right Deltoid ☐ Left Deltoid	Administered By			Administered Time
Manufacturer Pfizer-BioNTech	Lot	Expiration	Route IM	Dose Administered 0.3 mL

PATIENT INFORMATION:				
First Name	**Middle Initial**	**Last Name**		**Date of Birth (MM/DD/YY)** / /
Street Address		Primary Phone Number		Secondary Phone Number
City		State	Zip	County
Health Insurance (Choose) ☐ Private ☐ Medicaid ☐ Medicare ☐ Self Pay				
Gender ☐ M ☐ F ☐ Other	Race ☐ White ☐ Black ☐ American Indian ☐ Asian ☐ Pacific Islander ☐ Other		Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown	

RELEASE AND ASSIGNMENT:

I have been given the Fact Sheet for Recipients and Caregivers Emergency Use Authorization (EUA) of the Pfizer COVID-19 Vaccine to Prevent Coronavirus Disease 2019 (COVID-19) In Individuals 16 Years of Age and Older. I have read the sheet and have had my questions answered to my satisfaction regarding the COVID-19 Vaccine, including the risks, benefits, and possible adverse reactions or complications associated with the vaccine. My signature below indicated I, hereby, consent to and authorize the Medical Center of South Arkansas through its designated agents or representatives, to administer the COVID-19 Vaccine. I acknowledge that no guarantee or assurance has been made to me regarding the vaccine. The facility, by making this vaccine available to me, provides no warranty to me with respect to the vaccine.

Recipient Signature or Legal Representative			Date/Time
Relationship to Patient	Interpreter, if Utilized		Date/Time
Witness Signature	Date/Time	If Telephone Consent, Second Witness Signature	Date/Time