GEORGIA DEPARTMENT OF PUBLIC HEALTH

Pfizer COVID-19 Vaccine (Age 5-11)
INFORMATION AND CONSENT FORM

NAME (Last)	(First)	Date of Birth: _____/_____/_____	**Age:**
ADDRESS		**EMAIL**	
CITY	**STATE** / **ZIP**	**DAYTIME PHONE NUMBER**	
EMERGENCY CONTACT: **Name**	**Relation**	**Phone Number**	

Race: (check only 1)	**Ethnicity: (check only 1)**	**Primary Language:**	**Gender:**
☐Asian/Polynesian ☐Black ☐Multiracial ☐Native Am/Alaskan ☐White ☐Unknown	☐ Not Hispanic ☐ Hispanic ☐Unknown	☐ English ☐Other	☐Male ☐ Female

Vaccine	State Eligible code (GIP)	Site	VIS(Mo/Yr)	Procedure code
Pfizer-COVID-19	COVZ	IM	10/2021	91307

Please answer the health questions below:	Yes	No	Do Not Know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine? *If yes, which vaccine product: ☐ Pfizer ☐ Moderna ☐Janssen ☐ Other:			
3. Have you ever had a severe allergic reaction that required treatment with Epinephrine or EpiPen, or caused you to go to the hospital, caused hives, swelling, or respiratory distress including wheezing?			
*Was the severe reaction after receiving a COVID-19 vaccine?			
*Was the severe reaction after receiving another vaccine or another injectable medication?			

4. Check all that apply to you:
☐Have a history of myocarditis or pericarditis ☐Have a history of Guillain-Barre Syndrome
☐Have a bleeding disorder or take blood thinners ☐Have a history of heparin-induced thrombocytopenia (HIT)
☐Am currently pregnant or breastfeeding ☐Have received dermal fillers
☐Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
☐Diagnosed with multisystem inflammatory syndrome (MIS-C or MIS-A) after a COVID-19 infection

5. Check all that apply to you:
☐ Have a weakened immune system (i.e., HIV infection, cancer): If yes list condition: _____
☐ Take immunosuppressive drugs or therapies: If yes, please list: _____

I have been given a copy and have read the Emergency Use Authorization (EUA) and reviewed the FDA Fact Sheet for Recipients and Caregivers for the COVID-19 vaccine product I will be administered (choose one of the following):
____Pfizer (age 5 through 11) I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine indicated and ask that it be given to me, or the person named for whom I am authorized to make this request.

My signature acknowledges that I was advised to remain on site for 15 minutes after receiving the vaccine.
Those with previous anaphylactic reactions should stay for 30 minutes

_____ _____ **X**_____
Date **Print Name** **Patient or Parent/Guardian Signature**

FOR ADMINISTRATIVE USE ONLY

Vaccine recipient provided:
☐ Pfizer (age 5 through 11) https://www.fda.gov/media/153717/download

Payment Method: ☐ No Insurance
☐ Medicare (Part B)
☐ Private Insurance
☐ Medicaid/CMO
_____ Member Number _____ Group Number

Are you the primary card holder?
☐ Yes (Stop here)
☐ No (complete section)

_____ Name of insurance/HMO
_____ Primary card holder name

Vaccine	Dose	Route	Date Administered	Vaccine Manufacturer	Lot #	Expiration Date	Name of Vaccine Administrator/Provd #
COVID-19	_____ml ☐ 1st _____ml ☐ 2nd _____ml ☐ 3rd _____ml ☐ 4th	☐ IM - L Arm ☐ IM - R Arm ☐ IM - L Leg ☐ IM - R Leg					